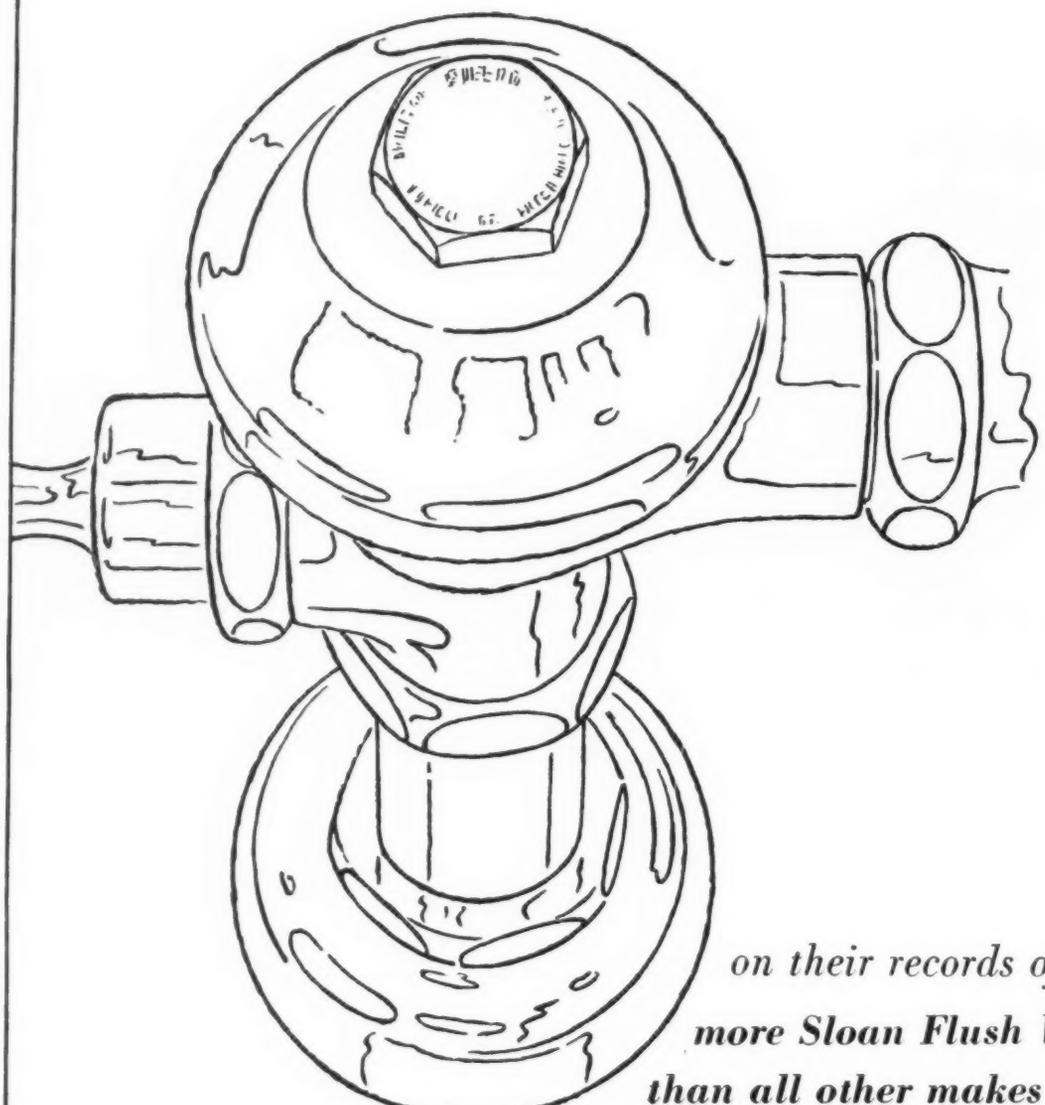
Conservation Is the Word for Norby
Salaries of Hospital Administrators
Quality Control in Purchasing

July
VOLUME 71 NUMBER 1
1948

The Modern Hospital



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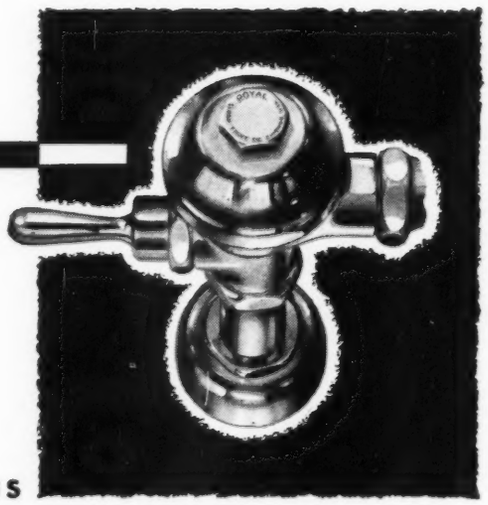

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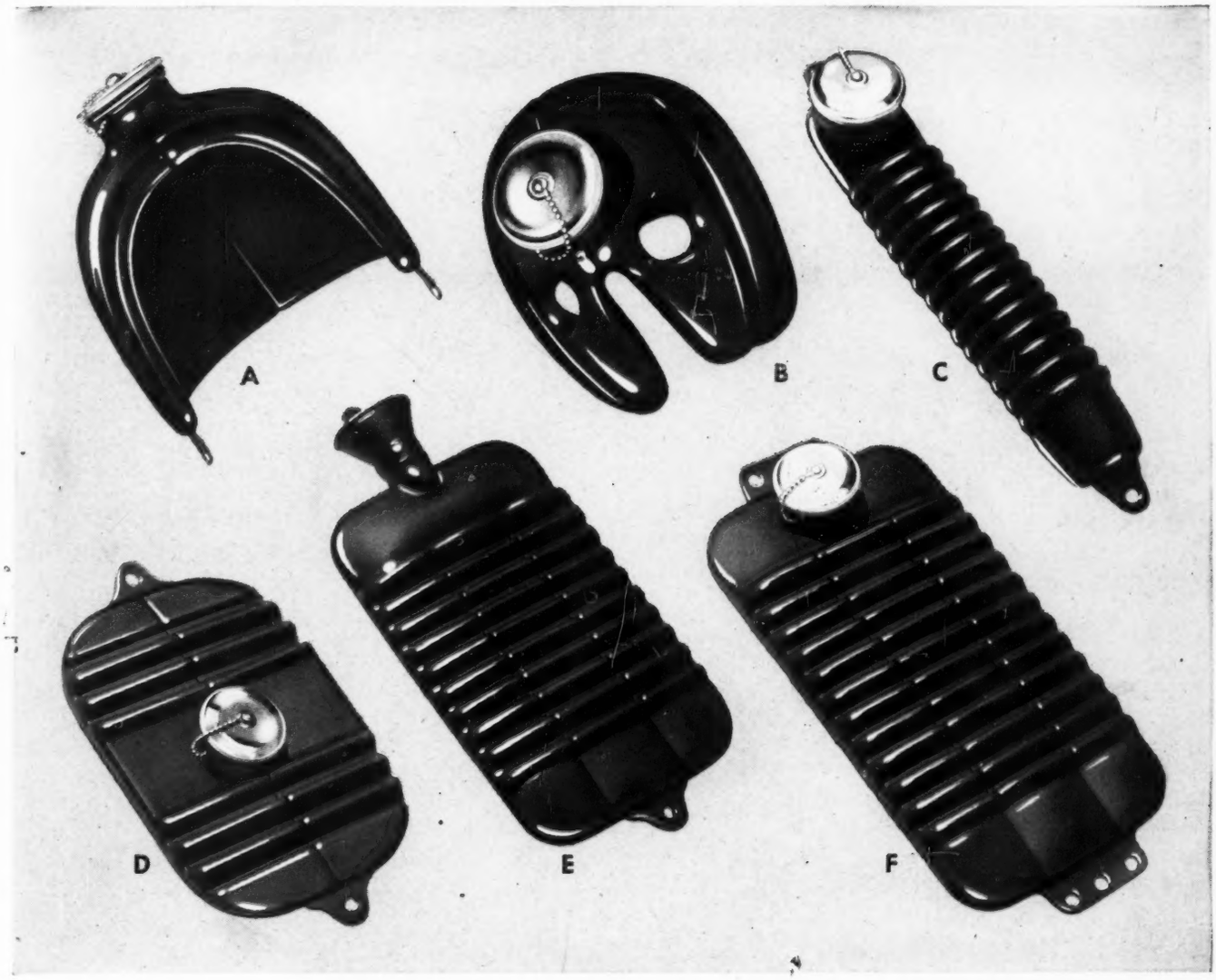

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Photograph by William Rittase

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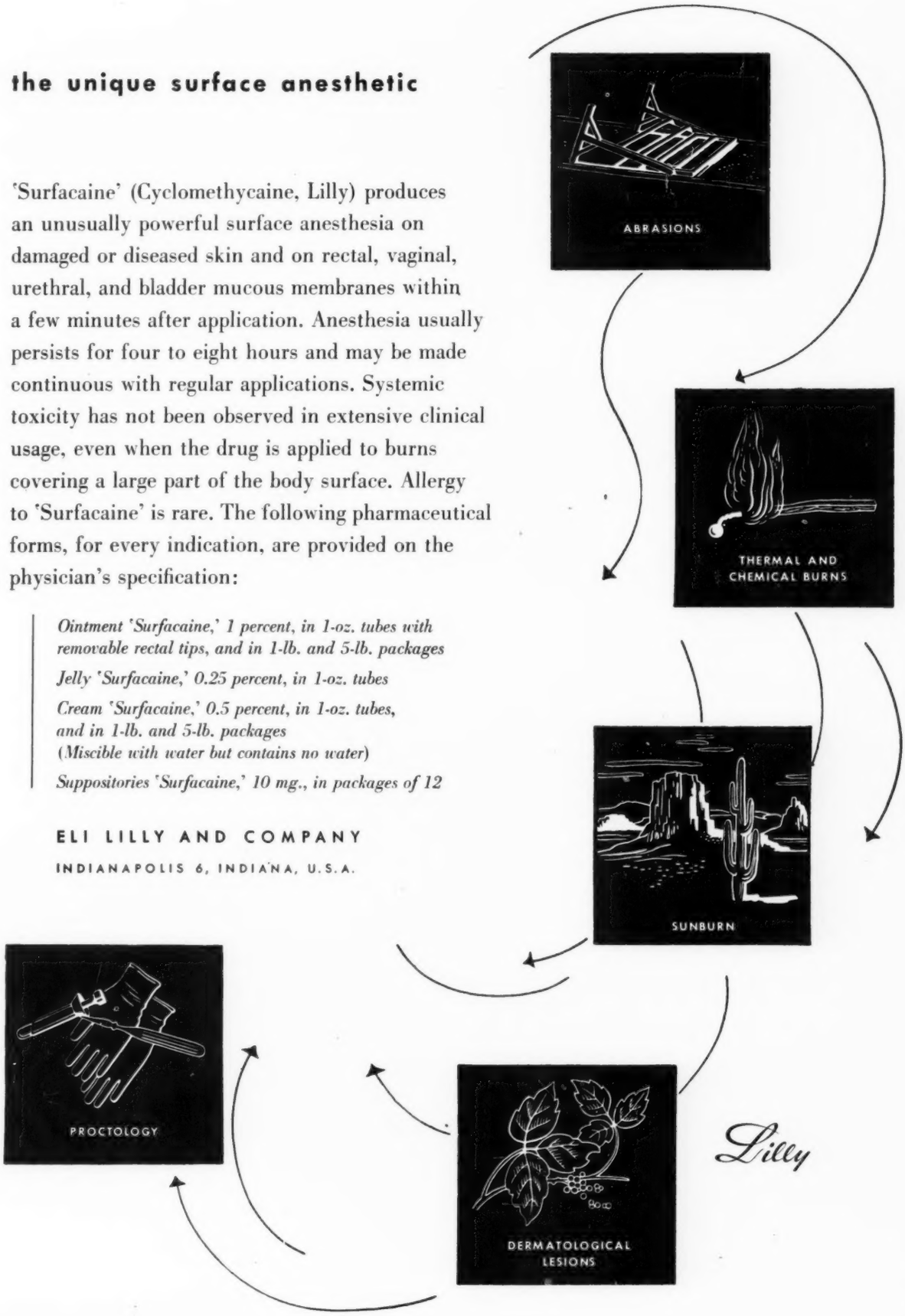

AMONG THE AUTHORS

Carl C. Lamley (left) receives the MacEachern Award from Everett K. Hunt, divisional manager of Johnson and Johnson.

Carl C. Lamley is administrator of Highland Park Hospital at Highland Park, Ill. He received the master's degree in hospital administration from Northwestern University last spring and was winner of the Malcolm T. MacEachern Award, highest honor in the Northwestern hospital program. A native of Ohio and a graduate of Ohio University at Athens, Mr. Lamley was a county auditor for several years following his graduation, then was cashier of the state treasurer's office.

Ola Gladys Hylton, Dr.P.H., has been a member of the social service staff at the University of Michigan Hospital, Ann Arbor, since 1923. She is now assistant director of social service, and her work includes direction of an educational program for members of the medical and nursing staffs and hospital patients. Dr. Hylton is a graduate of the University of Indiana and did her graduate work in public health at the University of Michigan. She is the author of several books and articles on medical social service.

Dorothy I. Anderson

As a member of the staff at the Renton Hospital, Renton, Wash., **Dorothy I. Anderson** divides her attention between dietetics and housekeeping. She joined the hospital at the time it was opened three years ago, following six years as dietitian-housekeeper at the College Hospital, Ames, Iowa, where she also taught home economics to Iowa State College students. A graduate of the University of Washington at Seattle, Miss Anderson studied dietetics at the California Hospital, Los Angeles, and has served on the dietary staff at King County Hospital, Seattle, and the Everett General Hospital, Everett, Wash.

Ralph B. Cundiff

Ralph B. Cundiff, a purchasing consultant with offices in Washington, D.C., has been engaged in hospital purchasing activities for the last fifteen years. A native of Illinois, he attended public schools there and went to the the University of Illinois. Mr. Cundiff, who lives in Alexandria, Va., is a member of national and local associations of purchasing agents and has contributed articles to trade and professional journals on purchasing problems and procedure.

Norbert A. Wilhelm, M.D., has been superintendent of Boston's famous Peter Bent Brigham Hospital for the last nine years. He is also a member of the board of trustees of the Washingtonian Hospital, a convalescent institution in Boston. Following graduation from medical school at St. Louis University in 1925, Dr. Wilhelm spent several years as medical director of a suger plantation in Puerto Rico. He was appointed assistant superintendent of Peter Bent Brigham Hospital in 1930. In 1937 he left Boston to become administrator of the Butterworth Hospital, Grand Rapids, Mich., where he remained for two years, returning to Brigham in 1939.

Roving Reporter

The Power of a Volunteer

"Never underestimate the power of volunteers" could well be the motto of most hospitals. It takes citywide connotation in St. Louis where two women —one an invalid, the other an occupational therapist—are well launched on the ninth year of a project that benefits shut-ins be they hospital or home patients.

The Volunteer Film Association, housed in the second floor study and bedroom of Marjorie Lang, takes movies to sick persons and old persons who cannot go out to movie houses. Miss Lang is a wheel chair invalid, has been for twenty years. Seated in a specially constructed chair, she directs the work of 450 members and volunteers who comprise the organization.

Assisted by a referring, previewing and booking committee, Miss Lang selects movies she thinks shut-ins will enjoy. She supervises the training of new volunteer motion picture operators, who take the equipment the association owns to an invalid's home, a hospital ward, or an old people's residence and give a projected performance on a specified day.

Movies in the children's ward of St. Louis City Hospital, one of many institutions for children and aged served by Volunteer Film Association.

This volunteer service has given 1350 shows to shut-in children and adults, 448 in hospitals and other institutions, and the rest in the homes of invalids. To date, 153 volunteer operators have been trained.

Susan S. Barnes is the occupational therapist who developed the project with Miss Lang. Miss Lang was among forty-eight "Women of Achievement" selected last year by the Group Action Council of St. Louis.

In Honor of the Women

The Mercy Diaper Club died twenty years ago. In its place was born the women's auxiliary of Menorah Hospital, Kansas City, Mo.

Now a twentieth anniversary is worth celebrating and Dr. David Littauer, director of the hospital, and the board were quick to see that an auxiliary older than the hospital itself should come in for high recognition.

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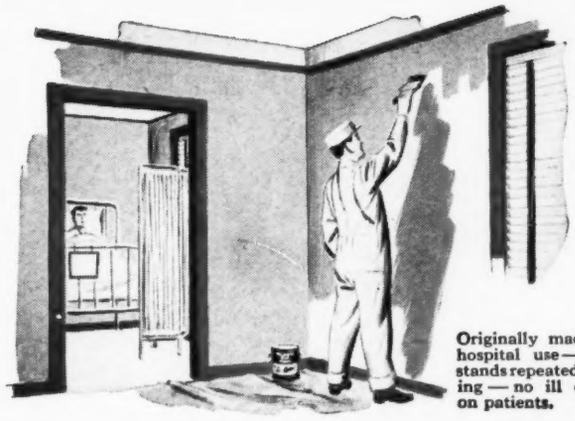

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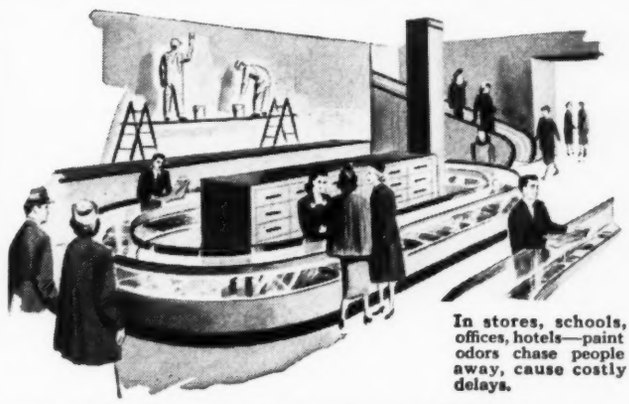

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So to three guest editors from the auxiliary the hospital turned over the May issue of the *Pulse,* the hospital nouse organ; seven of its eight pages tell in pictures and story the auxiliary's history and activities.

Fund raising came before service activities because the auxiliary's enthusiasm was caught by the idea of a Jewish hospital in the city and it went to work to raise funds. As its own initial contribution, the auxiliary promised to furnish all the hospital linens, draperies and silverware. There were only 200 members, and the men's group behind the hospital project thought the auxiliary somewhat overambitious. But it, too, underestimated the power of women.

A Giant Bazaar brought in $10,000, and this in the first year of the depression. A citywide dance realized another $10,000 in a single night.

Since the hospital opened in 1931, the activities of the auxiliary have been conventional but enthusiastic. A gift shop cleared $3000 in one year; the women have provided $16,500 worth of x-ray equipment; they have purchased $10,000 worth of radium for the cancer clinic; they donated the initial 500 books for the patients' library, a mobile collection which they staff; they furnished 140 aides during a single wartime month; they have supplied $60,000 worth of linens to the hospital, including their original gift.

Yes, the hospital could afford to turn over an issue of its bulletin to honor these women.

And No Questions Asked

Before taking leave of Menorah, we might tell you a little about Mrs. Rose Katz, an active auxiliary member who became a hospital patient. On the same floor with Mrs. Katz was a woman dying of cancer whose major concern was the fact that her husband would be hard put to it to meet the bills she was forced to be accumulating.

Mrs. Katz brooded over the matter and later came up with a $10,000 revolving loan fund restricted in its use to those who enter the hospital as full-pay but not long-term patients, only to find that complications develop that mean prolonged hospitalization with resulting financial embarrassment.

An unusual stipulation in the setting up of the fund was that persons receiving assistance from it should not be subject to investigation by a social worker or a social agency.

Don't think the social service agencies took kindly to the restriction, but during the first nine months' operation of the fund three persons have fitted perfectly into the conditions of the fund. Mrs. Katz further stipulated that persons aided by the fund have an opportunity to repay any part or all of the money advanced if and when possible and that the money thus received should be returned to the fund for future use.

Safety Council Reactivated

In a contest for an employes' slogan, this won at Middlesex Hospital, Middletown, Conn.: THE PATIENT IS OUR GUEST.

This institution has a safety council composed of one employe from each department. It has recently been reactivated, it being a war casualty. Officers are a laboratory technician, a maintenance man and the senior orderly. The group studies conditions within the hospital in an effort to prevent accidents.

READER OPINION

Truth on Fee-Splitting

Sirs:

The evils of fee-splitting and its prevalence are well set forth in the article by Greer Williams, "The Truth About Fee-Splitting," in The MODERN HOSPITAL for February.

This article is worth the perusal of every physician and surgeon, as well as every hospital administrator, every patient, and every prospective patient.

Seen in the broad aspect, with the unnecessary operations and incompetent surgery which frequently result, fee-splitting is a practice against which the profession and hospitals should, spurred by the aroused public interest today, take unified, militant action.

Malcolm T. MacEachern, M.D.
American College of Surgeons
Chicago

Blue Cross v. Insurance

Sirs:

The April issue of THE MODERN HOSPITAL carried a news item under the heading, "Insurance Man Challenges Blue Cross Superiority," about which I should like to offer some comments.

Commercial insurance companies are regularly "challenging Blue Cross superiority" for we often are placed in the position of competing for coverage of the same industrial group. However, the commercials have been content to let Blue Cross carry its benefits to rural areas and, in more and more cases, individuals without "challenge."

Historically, some insurance companies have been writing hospitalization coverage longer than Blue Cross plans have. Also historically, commercials were forced to broaden eligibility requirements and benefits to keep abreast of Blue Cross offerings. Until Blue Cross provided a family contract, the usual commercial insurance policy was available to the employed person only. As reported in your news columns, Mr. Hodges states the facts in reverse!

As far as commercial insurance companies' relations with hospitals are concerned, it is legally possible for commercials to pay hospitals only through assignment of the insurance claim check to the hospital. Commercial insurance companies pay the patient, not the hospital. Blue Cross pays the hospital *for* the patient. When a commercially covered patient enters a hospital, that institution has no assurance of having its charges paid by the insurance company.

To Mr. Hodges' last assertion that insurance coverage is preferable to Blue Cross because of uniformity nationally, let us recognize that each of the eighty-nine Blue Cross plans in the United States and Canada is tailored to the economics and professional practices of the area or community it serves. Rates charged subscribers and benefits given members are based on what the hospital economy will justify. An $8 a day commercial contract provides reasonably good coverage in the South but has the subscriber digging into his pocket in the East. What price uniformity there?

Richard M. Jones
Director
Blue Cross Commission
Chicago

For a Better Job

Sirs:

I have read carefully and with great interest the "Hospital Planning Round Table" in the March 1948 issue of The MODERN HOSPITAL. It is time that this subject was discussed in the open, and perhaps we could do a better job in the hospital field. Few people understand blueprints, yet I think all nurses, doctors and laymen who are administrators in hospitals should have this knowledge.

We should have a blueprint or job specification ready for the architect, who cannot be expected to know too much about the functions of the various departments. Hospitals have been supported in large part by interested philanthropists. Now that taxation has made many gifts impossible, it behooves us to put hospitals on a business basis.

It seems to me we should understand our objective, have a consultant if necessary (and I have seen some who did not know a thing about the subject), and I agree that the architect should finish the job.

Georgia H. Riley, R.N.
Director of Nursing Service
Glenn Dale Sanatorium
Glenn Dale, Md.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Pay Proportionate Share

Question: Does a community hospital have an obligation to support the Blue Cross insurance plan if the hospital consistently loses on Blue Cross patients? How can one ask other patients to underwrite this loss?—R.S., Me.

ANSWER: How is the loss calculated? On the basis of billings, collections or costs? Who is included in "other" patients? All of them or merely other private and semiprivate patients?

Blue Cross patients should pay their proportionate share of the costs of the service they receive from a community hospital. In the short run, this means that total cash receipts (per day or per case) from all Blue Cross patients should equal or exceed the cash receipts (per day or per case) from all other patients. In the long run, the Blue Cross patients should pay the full costs of their share of hospital services, whether or not other patients do so as a group.—C. RUFUS ROREM.

Who Checks Rooms?

Question: Should the nursing or the housekeeping department be responsible for checking rooms for occupancy after check-out cleaning has been done?—K.A.R., Fla.

ANSWER: Although the housekeeping department is responsible for the cleaning of the rooms, the nursing department is not relieved of the responsibility of being sure that the room is ready for occupancy after check-out cleaning has been done.

The housekeeping department is valuable, but there must be a correlation between it and the nursing department. The housekeeper is responsible for the cleaning throughout the hospital, but the nurse supervisor in charge of the floor is responsible for detail cleaning on her floor. By virtue of her training, she should be able to bring about the correlation between the two departments.—JEWELL W. THRASHER, R.N.

Interviewing the Recruit

Question: What are the main factors to stress when interviewing the possible candidate in nurse recruitment?—L.B.S., Conn.

ANSWER: We consider the main factors to stress to be the advantages and opportunities offered the professional nurse today. Point out that professional life is not one of drudgery but one of responsibility for which a period in nursing school gives the student the basic fundamentals only and enables her to exercise a choice in selecting the field that appeals to her most before taking advanced preparation.

Explain that rules and regulations are important in a school of nursing. Nurses are disciplined. Planned recreation to enable full development of personality is a feature of the student's education. If the interview takes place in the school of nursing, part of the time should be spent in showing teaching facilities and explaining their value. Do not glamorize the profession and pretend that a great deal of study is not required. An introduction to the faculty is desirable, if practical, especially the student counselor.—JEWELL W. THRASHER, R.N.

Requisitioning Linens

Question: Would you kindly outline a plan for the distribution and control of linen in a small hospital without a housekeeper?—B.F., Me.

ANSWER: Before you can arrive at any satisfactory solution to the linen control problem, you will want to answer the following questions: (1) How many sets of linen (standard) are needed to meet your daily needs adequately and efficiently; (2) how rapidly is linen returned from the laundry; (3) is the system flexible enough to meet emergency or holiday needs; (4) where does the linen that is lost go?

Any system used will probably have to be modified to meet the needs of the individual hospital, such factors as the architectural arrangement and the available personnel being taken into consideration. The responsibility for linen control may be combined with other duties. For example, the dietitian or the person in charge of sewing and linen repair might be utilized.

It is highly advantageous to have the same person check the linen closets on the floor, bringing the linen up to the daily established standard. A satisfactory system of requisition and distribution involves counting, sorting and storing linen in a central linen room on return from the laundry. All linen is sent out on requisition only. It does save nurses' time to have bath sets and daily linen changes distributed to the bedside of the patient. It also saves time to have linen kits prepared in advance. They should contain all the linen necessary to make up a room after the discharge of a patient. An efficient method for taking the linen inventory periodically and the cooperation of department heads are important parts of linen control.—PEARL R. FISHER, R.N.

Microfilming Approved

Question: We have a fifty-bed hospital established in 1941. The filing of our hospital charts is quite a problem as we do not have filing space. We are not a teaching hospital and many of our records are for obstetrical cases and are seldom referred to. Would you advise us to have them microfilmed?—E.I.B., Mich.

ANSWER: Microfilming is approved for many hospitals. Allied agencies in the hospital field advocate that a record be microfilmed or abstracted before disposition is made of the original record. —E. W. JONES.

Bar Expectant Fathers

Question: Are there any advantages in allowing the husband in the labor room? What are the disadvantages?—F.P.B., R.I.

ANSWER: I can see no advantage, and it would certainly be poor technic because of possibility of a break in asepsis. The husband's presence would, no doubt, be disrupting to the orderly routine of the delivery room. Often the inexperienced lay person may be disturbed by what to him are unfamiliar surroundings and may require the attention of personnel which should be otherwise engaged.—PEARL R. FISHER, R.N.

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Looking Forward

Education of Administrators

A RECENT survey among hospital administration students revealed a materialistic approach to the field that should give hospital leaders and educators something to think about. Most of the students said they were taking hospital training so they could get ahead faster. Many students spoke frankly of the prestige or label value of a degree, as opposed to the actual content of the training. Less than one-fourth of those surveyed named the humanitarian purposes of the hospital as a motivating force in their education.

Is this bad? Is it wrong to want to get ahead? In a world that judges performance by material results, can hospital students be blamed for material ambitions?

In all fairness, older administrators must search their own hearts before condemning these students for what may be simply an honest expression of attitudes that are widely shared. Probably there is no such thing as a purely humanitarian approach to hospital work, and no approach that is wholly materialistic. As every human being is an aggregate of good and evil forces, every administrator must bring to his tasks a compound of motivation, including some selfishness and some altruism.

Which of these predominates may seem comparatively unimportant, as long as the administrator is technically proficient. Yet there are times when he must choose between making a showing and doing a job; what is best for the administrator's career may not always be best for the hospital and its patients. In the world as it should be, the hospital would win all these decisions. In the world as it threatens to become, it may lose many of them.

If the student survey may be accepted as credible, it is evidence that the hospital courses are emphasizing technic at the expense of philosophy, an error that is characteristic of our time. Unless hospital educators and leaders enlarge their technical concept of the educational function, it seems likely that the students who are tomorrow's leaders may look upon the hospital more as a vehicle for their personal ambitions than as an organization of human beings devoted to the care of their fellow men.

Obviously, the right educational formula will not emerge quickly or easily. To make room in the hospital course or institute for a seminar on ethics, one must sacrifice a lecture on linen control. If religion is added, refrigeration may be subtracted. To find time for Augustine, the student must skimp on MacEachern. Nevertheless, it is possible that those who plan hospital programs can do more for the salvation of our system by facing these considerations than they could do in any other way. Behind the crest of our material fullness yawns a chasm of spiritual emptiness. If hospitals fall into it, there is little hope for other elements of our society.

Regional Conferences

FORMATION of the Middle Atlantic Hospital Conference has now been ratified by the memberships of the New Jersey, Pennsylvania and New York state hospital associations. The conference will meet annually in the spring, and the state associations are expected to discontinue their yearly conventions and hold only the business meetings necessary to carry on their activities.

Leaders in hospitals and hospital industries welcome this important step toward the regionalization of hospital assemblies. The regional system has many advantages. Regional hospital associations have the resources, in money and manpower, to give their conferences educational value and drawing

power that are beyond the means of all but a few of the state groups. When state conventions are discontinued, exhibitors are spared the effort and expense of keeping their shows on the road the year round. Unanimous enthusiasm for the recent meeting of the newly organized Upper Midwest Association forecasts similar success for the Middle Atlantic group.

The next logical step is to put both regional and national hospital conventions on biennial schedules, meeting in alternate years. In all conscience, one convention a year should give hospital administrators all the opportunity they need to keep up with new developments in the field, exchange ideas and gossip in informal bull-sessions, and get the needed perspective that distance and relaxation bring to their individual problems.

Attending a regional conference one year and a national convention the next, the administrator would have a better chance to hear talks he hadn't heard before and look over exhibits that seemed new and fresh. Exhibitors would approach a once-a-year show with vigor and enthusiasm that are understandably lacking now. Hospital trustees would approve convention expenses without misgivings, and everybody would be relieved of the nagging suspicion that too many hospital people attend conventions in the whingding instead of the educational spirit.

Ban the Lunatic Fringe!

DIFFERENCES of opinion that require disputants to define their views as clearly as possible and state their positions unequivocally are often a wholesome thing. The cold war between radiologists and hospitals, for example, may in time compel the radiologists to acknowledge that there is nothing unprofessional or iniquitous about a salary. It may also force hospitals to revise some illogical methods of rendering charges to patients. Because both money and principle are involved, this particular dispute is likely to go on for a long time, if not forever. Meanwhile, both sides are doing some introspective thinking, which probably won't hurt them.

Occasional skirmishes in this war, however, have been carried to a point where innocent bystanders are injured. Because of a falling out between one hospital and its radiologist, or ex-radiologist, it is reported, patients have been removed from their beds, taken by ambulance to a private x-ray laboratory, then returned to the hospital for continued treatment.

From a distance, it is impossible to tell who was right and who was wrong in this case; possibly there was some justice, and some error, on both sides. Whatever the merits of the dispute, however, such willful neglect of the patient's welfare is disgraceful and will ultimately harm everybody. This is the kind of juicy incident opponents of the voluntary medical care system are looking for and will eagerly seize, claiming it as evidence that the system is decaying. Actually, of course, it indicates only that fools and fanatics may be found within the system as well as among its enemies.

If hospitals and radiologists can't carry on their differences without clipping their patients, the system isn't as good as we think it is and no amount of fancy footwork will save it. In the interest of the sport, both teams should banish players who get rough.

The Workman and His Tools

SPEAKING at an American Surgical Trade Association meeting not long ago, Dr. Morris Fishbein delivered a body blow to the simplification and standardization movement, surgical needle division. "If I were going to have a surgeon operate on me," Dr. Fishbein declared, "and he wanted a needle of a certain type, with a certain eye and a certain width, a certain curve and a certain cutting edge and a certain length, I want him to have that needle!"

Dr. Fishbein's meaning is plain; obviously, standardization must never be carried to a point at which the surgeon's effectiveness is limited. Shrewd economist that he is, however, Dr. Fishbein would probably agree that the cost of medical care would soon soar out of sight if we had to build a different needle for every surgeon.

Unquestionably, there are a few surgical geniuses whose skill is so delicately tuned that a size 0000 needle will serve where a size $0000\frac{1}{16}$ will not. For the assistant geniuses and subgeniuses who do all the work in most of the nation's hospitals, however, substitution of a certain certain for a certain certain certain type should not bring on nervous collapse or threaten the surgical result. The effort to achieve economy through standardization of supplies must be based squarely on the surgeon's needs, of course, but it must not be obstructed by the false notion that off-standard demands are the hallmark of genius.

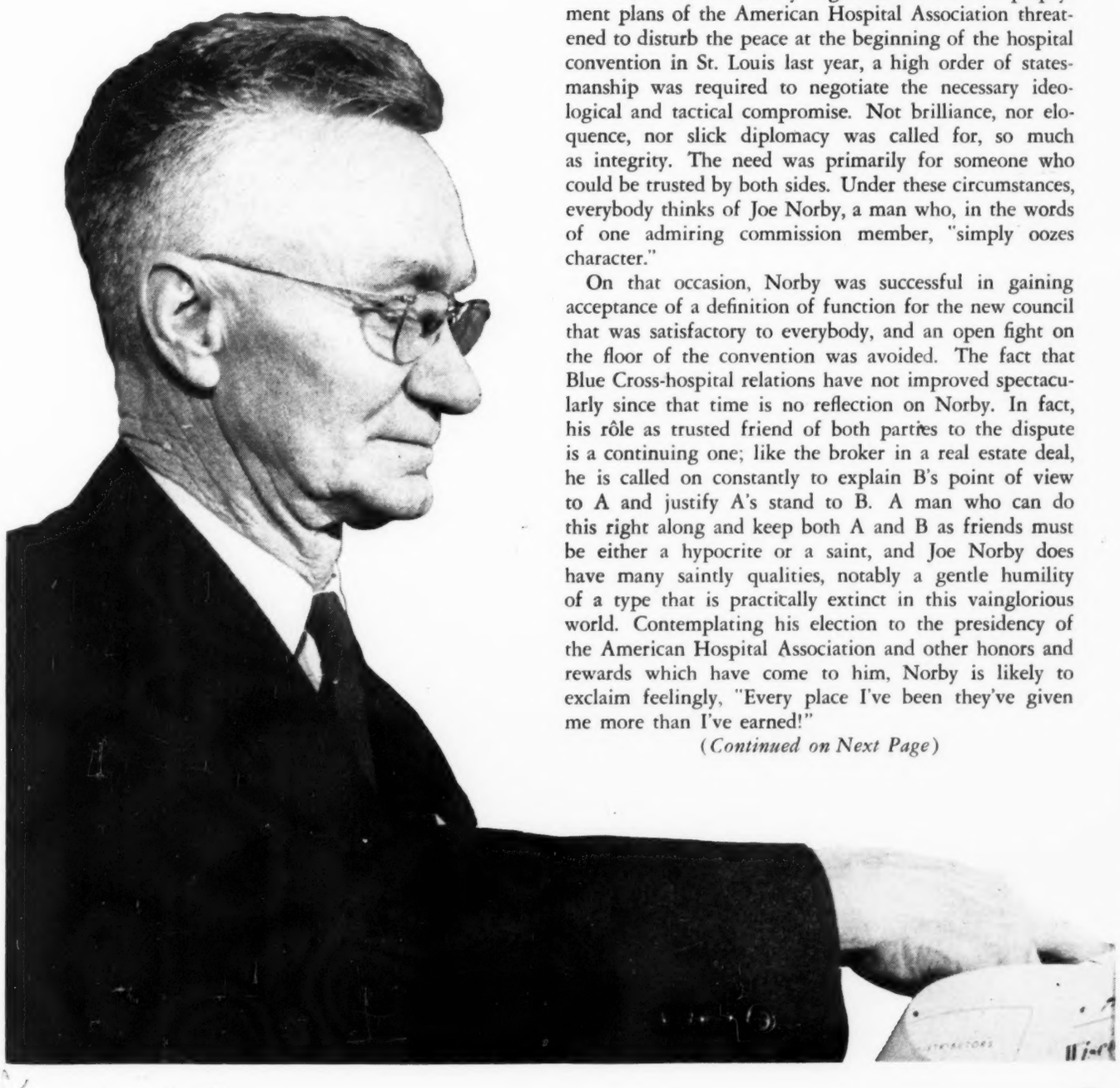
Hallelujah!

THE work stoppage which held up production of the last several issues of The MODERN HOSPITAL has ended, and this copy was printed on our own lot. We look forward now to an early resumption of diplomatic relations between our dateline and our calendar.

CONSECRATION IS THE WORD FOR NORBY

The A.H.A. president-elect's story is one of service without stint and politics without cabbages

ROBERT M. CUNNINGHAM JR.



WHEN a collision between the Blue Cross Commission and the newly organized council on prepayment plans of the American Hospital Association threatened to disturb the peace at the beginning of the hospital convention in St. Louis last year, a high order of statesmanship was required to negotiate the necessary ideological and tactical compromise. Not brilliance, nor eloquence, nor slick diplomacy was called for, so much as integrity. The need was primarily for someone who could be trusted by both sides. Under these circumstances, everybody thinks of Joe Norby, a man who, in the words of one admiring commission member, "simply oozes character."

On that occasion, Norby was successful in gaining acceptance of a definition of function for the new council that was satisfactory to everybody, and an open fight on the floor of the convention was avoided. The fact that Blue Cross-hospital relations have not improved spectacularly since that time is no reflection on Norby. In fact, his rôle as trusted friend of both parties to the dispute is a continuing one; like the broker in a real estate deal, he is called on constantly to explain B's point of view to A and justify A's stand to B. A man who can do this right along and keep both A and B as friends must be either a hypocrite or a saint, and Joe Norby does have many saintly qualities, notably a gentle humility of a type that is practically extinct in this vainglorious world. Contemplating his election to the presidency of the American Hospital Association and other honors and rewards which have come to him, Norby is likely to exclaim feelingly, "Every place I've been they've given me more than I've earned!"

(*Continued on Next Page*)

Genuine as it unquestionably is, Norby's humility does not keep him from taking sides in a fight. On the contrary, there is rarely any doubt about where he stands, and, when vigorous expression is called for, he is usually equal to the occasion. At the Blue Cross-Blue Shield commission conference in Los Angeles last March, for example, Norby felt constrained to apply the brakes to the movement toward formation of a national insurance company that some observers felt would largely supersede the existing plan agencies. In a two-minute speech, he made his position in this complicated matter explicitly clear. Describing the proposed corporation as a "super body," he said it might impair the autonomy of the commissions, reduce them to an advisory capacity, jeopardize hospital support, and "conceivably become as obnoxious as government itself, or even more so, inasmuch as the proposed association would not be directly responsive to the agencies giving the service."

He was graduated from St. Olaf College, Northfield, Minn.

EARNED RIGHT TO CRITICIZE

The fact that Norby could talk like that to Blue Cross executives who were ambitious for the national plan, and yet remain on the friendliest terms with them, may owe as much to circumstance as to saintliness. If any hospital administrator has earned the right to criticize Blue Cross, Joe Norby has. He assisted at the birth of Blue Cross in Minnesota and, later, Wisconsin, served both these plans as president and board member, and has been a member of the national commission for several years. On one occasion, as a matter of fact, Norby was willing to sacrifice his job for the good of Blue Cross—a situation that probably has few parallels in the history of the movement.

When Blue Cross was in the early stages of its organization in Wisconsin, a powerful group of doctors in Milwaukee, and some hospital people, were strongly opposed to the idea, which they regarded as only slightly less iniquitous than socialized medicine. Norby, who had recently been appointed administrator of Milwaukee's Columbia Hospital, was an enthusiastic supporter of the prepayment movement, which he had helped to organize in Minnesota a few years before. On the other hand, the president of his board of trustees, a conservative businessman, was lukewarm at best and certainly didn't want the hospital mixed up in the conflict that was taking shape.

When word got out that Norby was scheduled to preside at an organization meeting that was fairly certain to erupt in heated debate, if not gunfire, the board president was horrified and didn't hesitate to say so. Norby, who felt he could help put the program across and knew that hospital people all over the state were counting on him, refused to budge. Eventually, the president called him on the telephone and told him point blank not to preside at the meeting. "Furthermore," he added sternly, "I'll be there to see whether you do or not."

He was, and Norby did. The expected fight failed to develop, and subsequently the board president acknowledged that Norby was right and he was wrong, a circumstance which did not prevent another board member, however, hearing about the incident from Norby himself, from suggesting that he be fired for insubordination.

Norby is now well along in his twelfth year as administrator at Columbia. His previous, and first, hospital job lasted fourteen years. In a profession characterized by occupational wanderlust, this kind of stability must obviously have a wider base than strong character and a passionate interest in Blue Cross, desirable as these qualifications may be. In Norby's case, the other factors are a thorough knowledge of hospitals and administrative ability.

An analysis of Norby's administrative methods may support the view that an administrator, like a flautist, is born and not made. As he conceives it, it is Norby's function to make certain that able people are directing the various elements, or departments, of the hospital, to keep himself informed of their problems and their results, and to provide the means of resolving the many difficulties that arise to make any hospital administrator's day a sort of intellectual obstacle course.

The ingredients of an adequate intelligence system and problem solving mechanism, which may be described as the science of hospital administration, can probably be taught, but the art of picking and holding good people is as individual and personal as the shape of a man's nose or the sound of his voice. Some administrators attract executives, as a light draws insects, by the brilliance of their individual knowledge and performance; this explains the occasional phenomenon of the boss who is thoroughly hated by employes who, nevertheless, wouldn't think of working for anybody else. The success of others is based on the sort of genius for friendship that makes every subordinate a personal confidante and pal. It is likely that Norby enjoys the loyalty of his associates not so much for either of these reasons as because he is devoted to them and they know it.

THEY FIXED THE PLACE UP

Possibly the key to this reciprocal feeling lies in an experience of many years ago, when Norby was superintendent of Fairview Hospital in Minneapolis. A trustee of the hospital had donated some farmland outside the city, and Norby decided to fix the place up as a recreation center for student nurses and hospital employes. Every evening when the hospital office closed, Norby and half a dozen or more of his employes would pack a picnic supper, drive out to the farm and work like coolies until dark—spading the garden, painting the house, patching screens and doing other chores that most administrators recognize only as entries on a work sheet. According to a report from one of his co-workers at the time, Norby is a very fast man with a lawn mower.

In addition to making him a hero with the hired help, Norby's lack of side enables him to run his hospital with considerably less strain than is often required in institutions where dignity and distance must be main-

tained. The whole Columbia operation under Norby is characterized by absence of protocol. Where some administrators are insulated by a thick layer of paper made up of daily, weekly and monthly reports from everybody on the premises, Norby gets along with only the necessary minimum of fiscal and statistical communiqués, running the hospital meanwhile by ear or, to use a phrase once employed by Dr. Robin Buerki, "by the seat of his pants."

He manages, too, without the full-scale executive or administrative conferences which are a periodic ritual in so many hospitals. The greater part of the time spent in these meetings is likely to be wasted anyway, Norby believes, since few of the problems discussed can ever affect more than one or two departments at the same time. Thus, while the interested parties in any one instance are airing their views, or, as is often the case, wrangling, everybody else in the room is marking time. The cross-fertilization of departmental viewpoints that is the main purpose of such meetings can be accomplished by the administrator himself, Norby maintains, with considerable economy in unnecessary arm-waving.

Norby's method is to route all the principal department heads through his office every day for informal chats aimed at keeping him abreast of what he calls, inelegantly, "their stuff." When the occasion warrants it, he may bring two or three people in at once to focus their attention on some specific problem in which they are directly concerned. If the problem involves any medical or nursing procedure, however, it is referred immediately to a group that Norby regards as one of the mainsprings of the hospital organization, the Interprofessional Committee, consisting of four nurses, four doctors, and the chief resident. It is the function of this committee to thrash out all matters of professional service. According to Norby, the method works. Acting on complaints from several staff members, for example, the committee recently overhauled the hospital's system for administering transfusions. The new plan, which sets up a special transfusion unit or task force, is satisfactory not only because it's a good plan but also because everybody wants it to work, an advantage often missing from procedures that are conceived unilaterally.

On Columbia's board of trustees, the committee method of operation holds full sway. Separate trustee groups concern themselves with nursing, housekeeping, maintenance, finance and other phases of hospital activity. Unlike similarly labeled committees on other boards, the Columbia units function like mad all the time, holding meetings, informing themselves and offering their counsel to Norby and his assistants as the need arises. There are no doctors on the Columbia board, but the chief of staff is an ex officio board member and attends all meetings. The board meetings are largely taken up with reports from trustees who are committee chairmen. "I just make a brief statistical report and answer questions," Norby insists.

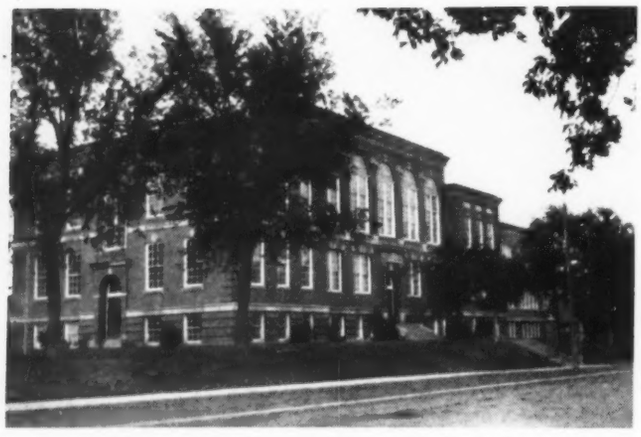
Norby learned hospital administration the way a dog learns to swim, by plunging into the icy water and doing what comes naturally. Born into a minister's family in South Dakota in 1883, Joseph Gerhard Norby was graduated from St. Olaf College, a Lutheran institution at Northfield, Minn., in 1904. He spent the next fifteen years in public school administration, first as a high school principal, then as superintendent of schools in several Minnesota towns. In 1919, prompted by an admiring banker in Fergus Falls, where he had been school superintendent, he went into the banking business and spent the next four years making loans to Minnesota farmers.

Norby never did find out exactly how he got into the hospital field, of which he is now the high priest. "Fellow I knew in college was on the board of this hospital and thought I'd make a good superintendent," is the way he explains it. At any rate, the suggestion came in 1923, when credit was tight and Norby didn't have much to do at the bank, so he went over to Minneapolis to talk to the Fairview Hospital people and look things over. Things looked pretty good, and he accepted the job. As he recalls it now, one of the points that impressed him most was the fact that there was a national association of hospitals. "Nice little group, too," Norby thought at the time. He's never changed his mind.

The president of the hospital board met Norby in his new office the first morning he came to work. Opening a drawer, the president pulled out a sheaf of suppliers' bills and slapped

Ball Player Norby is second from right, top row, 1904.

The Norby family at fortieth wedding anniversary, 1947.



FROM HERE: Principal of Fergus Falls high school.

TO HERE: Administrator of Columbia Hospital.

them down on the desk. "Better pay these right away if you've got the money," he said, and walked out. That was the only formal instruction Norby ever had in hospital administration. Aided by a medical dictionary, which he pored over the way a child reads comic books, he survived the early weeks of strangeness. After that, he got along fine.

Unlike some of those who had to learn the hard way, Norby is not at all skeptical about the special training hospital administrators get today. In addition to providing an excellent background for young administrators, he thinks, the college courses and the many special institutes that are offered now have raised the level of administrative practice throughout the entire field. But, he adds, there is no substitute for the understanding of human relationships that must be achieved, so to speak, under combat conditions. "I've had administrative assistants, fresh from university training, who were impatient because I didn't simply lay down the law and make something work the way they learned it," Norby relates. "They hadn't had time to find out that frequently you have to wait for human nature."

This insistence on a top-dressing of practical experience does not indicate any lack of respect for formal education. On the contrary, Norby's deep interest in education is shown by the fact that he has been president of the board of trustees of St. Olaf College for sixteen years—a period, it should be noted, which includes a number of years when it wasn't much fun to be president of anything. In the hospital field, he has consistently advocated supporting the hospital's educational function with adequate educational facilities, a view that finds concrete expression in Columbia's generous space for classrooms, teaching laboratories, and demonstration wards. In one of his early major steps as administrator of Fairview more than twenty years ago, Norby took over a tuberculosis hospital, emptied it of patients and made the building over as a school for nurses. "If we're going to educate nurses, let's educate them, and not just talk about it," he declared then, articulating a concept that was, to say the least, considerably ahead of its time. Incidentally, he didn't hesitate to take the dispossessed tuberculous patients into the general hospital—another move that was twenty years ahead of the field.

Norby's interest in nursing education and nursing service has never been keener than it is today, and the current confusion of economic and professional pressures in nursing has not prevented him from keeping the main issues clearly in mind. At a time when hospital and nursing executives everywhere are breathing hard and pawing the ground with one foot, he has contributed some incisive comments that cut down to the core of the problem. "Those responsible for the education of nurses have not been alert to the changes that have taken place in medical and hospital practice during the last fifty years," he said at a recent nursing conference. "On the one hand, scientific training has been stressed. On the other, the nurse has been required to continue to perform routine household duties, her term of training remaining the same as it was in the days when she was serving an apprenticeship and working out her training and keep. There is no common agreement among administrators as to just what kind of nurses are needed for all the demands of hospitals and other fields, but there is general agreement that the present system is not producing nurses in the variety that a changing society demands."

Reporting the results of an informal survey of administrative opinion that he made himself, Norby concluded, "My correspondents were unanimous in declaring that the nurse was to a large degree being exploited by a system based on educational theory and extended much beyond the essentials, both in time and subject matter, necessary to proper production of the type of nurse most needed at this time. The current system lays more stress on orthodoxy than on realism."

Of course, these views are not new. As a matter of fact, Norby himself expressed many of the same ideas some time ago in a paper he prepared for a hospital meeting. "Certainly there are at the present time two quite divergent opinions as to the functions of the nurse," he said then. "One holds that she is a well trained technician, educated to care for the sick under the direction of the doctor. Her training, therefore, should be of a vocational nature calculated to fit her for doing the tasks that naturally fall within this vocation. This is the bedside nurse and the type that is best known to the public. Others hold her to be a highly professional person whose duties are largely pedagogical and administrative, still adjunctive to the doctor, but not dependent upon him to the same degree assumed by the first group. To produce these two

distinctive types will require different methods of education, and the agencies now active in the work of producing nurses will need to know what their aims should be and what type of product is desired."

Presented at the A.H.A. convention in Detroit in 1932, these statements were prophetic of the solution that is taking shape in Norby's mind today: a course of not more than two years, and possibly less, with emphasis on the practical nursing arts, which would graduate what Norby thinks of as the "basic nurse" for general hospital duty. For specialized functions, executive positions, and teaching, there would still be degree courses. But, he cautions, "there is no agreement that all instructors who come in contact with students need to be degree nurses. Directors, assistant directors, and teachers of academic and scientific subjects may well be college trained. In the practical courses, special training beyond the R.N. is necessary, but good experience is essential. The teacher must be properly prepared for her function. This involves academic and technical training, experience in the field, and the personal qualities which present her to her students as a model to be emulated."

AGAINST ECONOMIC SANCTIONS

While the final answers in nursing are being worked out along these or other lines, Norby has no patience with the nurses and nursing leaders who are applying economic sanctions on hospitals through their professional organizations. He has never declared himself publicly as opposed to collective bargaining for nurses, but a statement he made a year ago plainly reveals his thoughts on the subject. In contrast to other nurses' associations, which were waving lead pipes in the air pretty freely at the time, the Wisconsin nurses had just approved a conservative resolution recommending the establishment of personnel policy codes in hospitals and seeking voluntary cooperation from the hospital group. Collective bargaining effort should be postponed until the effectiveness of the voluntary program could be determined, the resolution said, tossing the lead pipe into the ashcan.

"Wisconsin nurses are to be complimented on the stand they have taken in relation to this whole matter," Norby wrote in the *Bulletin* of the Wisconsin Hospital Association, of which he was then president. "Every effort should be made by Wisconsin hospitals to cooperate closely with nurses in this very intelligent program. It reflects a good professional spirit."

Looking ahead to his coming year as A.H.A. president, Norby thinks the nursing problem is the biggest thing in sight. "If I can contribute something to the solution of that," he says frankly, "I'll have done all I could hope for." While this kind of statement is in the pleasant tradition of modesty becoming those about to take office in voluntary associations, there can be no questioning Norby's sincerity.

The presidency offers him nothing in the way of career opportunity or excitement, as it might have, say, ten years ago. At sixty-five, he has the relaxed benignity of a man who has got where he's going. With Mrs. Norby, he lives in a comfortable apartment within walking distance of the hospital. In addition to Maurice, their eldest son, who is an assistant director of the headquarters staff of the A.H.A., the Norbys have a son who is an army doctor now stationed in Japan; another son who was a navy flyer during the war and is now in business in a small Wisconsin town; three married daughters, and, at the last accounting, eight grandchildren.

In appearance, Norby combines certain features of Abraham Lincoln and Popeye the Sailor. If it weren't for a square, outthrust jaw like Popeye's, his tall, angular frame, deeply lined face, and high forehead could easily win him the Lincoln rôle in a theatrical company; it would be necessary only to darken his iron-gray hair and add sideburns and a beard. Norby's rugged, bony visage, as a matter of fact, contains precisely the elements Lincoln must have had in mind when he said, in one of his campaign speeches, "In my lean, lank face nobody has ever seen that any cabbages were sprouting."

Norby has always enjoyed the cabbageless politics of the A.H.A. On at least two occasions, he has publicly described the office he is about to assume as "great." The second time was when he was named president-elect in St. Louis last September. The first was eighteen years ago, when he played a leading part in the only successful rebellion ever staged on the floor of an A.H.A. convention. The nominating committee had submitted a slate headed by Robert E. Neff of the University of Iowa Hospitals when the insurgent group, sparked by Norby and Robert Jolly of Texas, jumped up to nominate Paul H. Fesler, then superintendent of the University of Minnesota Hospital.

One amusing feature of the oratorical contest that followed was the repeated emphasis, in an elegant nominating speech by Jolly, on Fesler's origin "west of the Mississippi River," when the fact was that Fesler's University of Minnesota Hospital hugged the east riverbank, whereas Neff, the regular candidate, came from a spot fifty miles west of the Mississippi. This was noted during the discussion by a delegate from Des Moines, who observed dryly that he had "left Iowa about a week ago and at that time it was still west of the river." Norby's part in the meeting was confined to a seconding speech for Fesler which included his reference to the "great office of president."

INSURRECTIONISTS REBUKED

In the election that followed, Fesler won by twenty votes. At the final meeting of the convention that year, Richard P. Borden of Massachusetts, who was retiring after many years as an A.H.A. trustee, delivered a pointed rebuke to Norby and his rebellious associates when, in his retirement speech, he said, "It is a high honor to be an officer of this association, if the office seeks the man rather than the man seeking the office. . . . I do not mean to say that the nominating committee is infallible, but I suggest that, with few exceptions, the best advice you can get in the choice of your future officers will be found in the suggestions of your nominating committee."

The delegates have never again ignored Borden's advice, and it has never worked better than it did last year when they named Joe Norby, a man whose spirit typifies the service ideal of the American hospital system. Reporting to Wisconsin hospitals last year, Norby spoke soberly of the many problems looming on the hospital horizon and the intelligence and effort that would be needed to solve them. "We may look forward with joy to the larger services that we will be enabled to offer our people through our hospitals," he concluded. "This will require consecration on the part of us all."

Unquestionably, consecration is the word for Norby.

Richard Collins, Des.

An Additional Plan for the Coordinated Hospital System

THE TWENTY-FIVE BED HOSPITAL

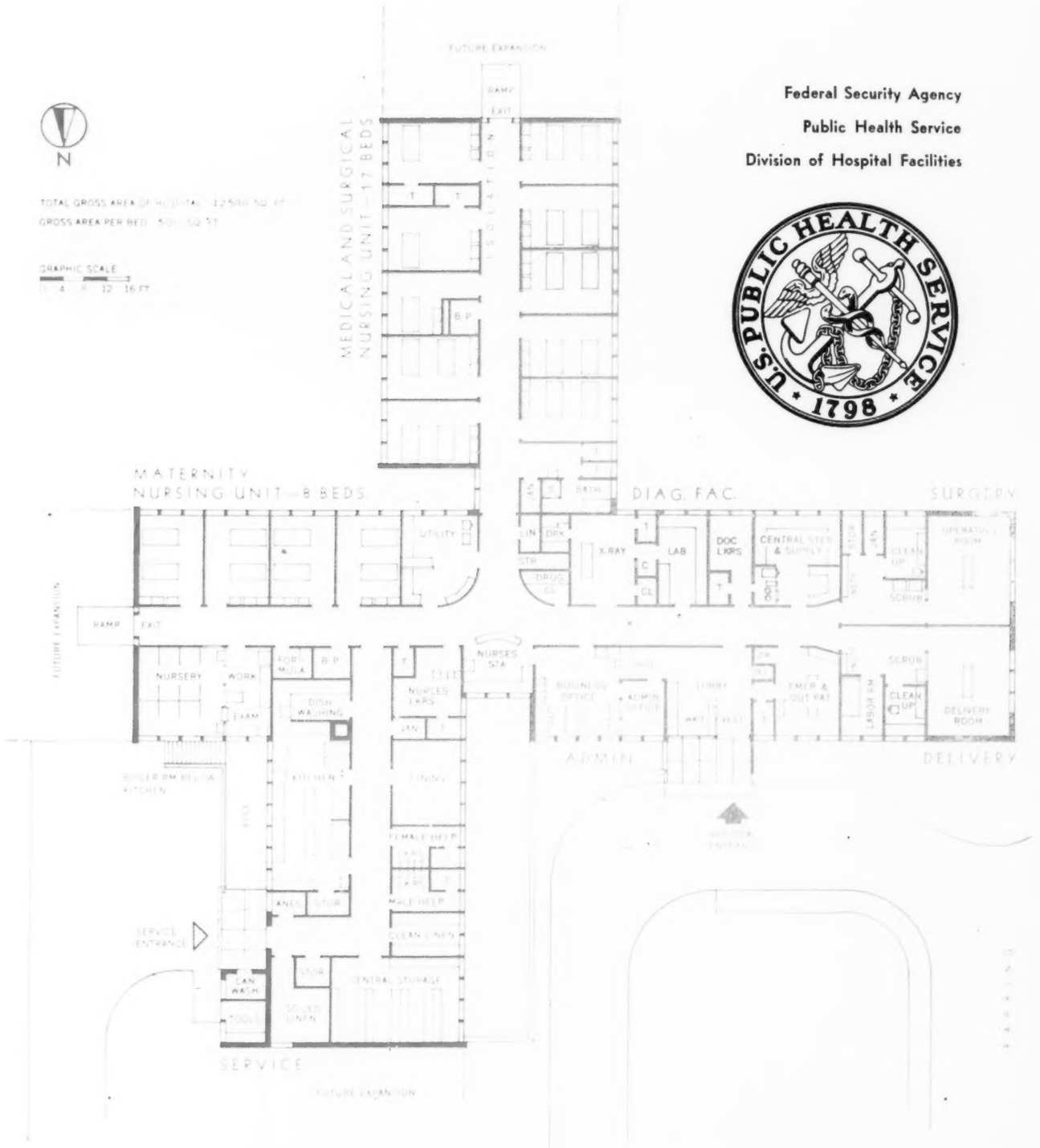
ONE of the most controversial questions in the hospital and health fields is the relative value of the institution having fewer than fifty beds. Opinions range from the extremes that no community is justified in attempting to maintain such a facility to the belief that any type of service is better than none. Small hospitals are disproportionately expensive to build and to operate. When measured in terms of adequacy of patient care, they fall within the range of diminishing returns from the standpoints of efficiency and economy. While in actual dollars it may seem that costs of operation are not excessive, the various services needed for complete care cannot be maintained on the financial basis existing in the average small hospital.

Much must be done if modern diagnostic and therapeutic measures are to be made available to the general population. In hospitals of fewer than fifty beds in the United States, only 63 per cent have a clinical laboratory, 79 per cent, x-ray diagnosis, 17 per cent, a medical library, 55 per cent, a metabolism apparatus, 33 per cent, an electrocardiograph, and 13 per cent, x-ray therapy. Despite these limitations, many rural communities are faced with the dilemma of providing some type of facility, even for limited services, or of being dependent for medical care upon urban areas too distantly situated.

Shortages of physicians, dentists, nurses and other medical personnel are marked in many communities, and, in general, medical personnel is unequally distributed throughout the country. This inequitable distribution exists among states and among local areas within the same state. The distribution of physicians is governed by a number of factors, most important being community purchasing power and availability of adequate hospitals.

The presence of hospital facilities alone appears to be one of the largest factors in attracting physicians to a community. This fact was understood and discussed at great length by members of Congress and leaders in the hospital and health fields who appeared before Congressional committees in support of Public Law 725, which was enacted by the 79th Congress to inaugurate a national hospital program. This law, which has almost unanimous endorsement by the medical profession, hospital associations, national and state groups, has been promoted with enthusiasm by the states.

The need for medical care in rural areas is as great as it is in urban centers. One of the prime requirements of the law is that priority be given to rural and low income areas. The responsibility for the determination of such priorities, along with most of the other requirements of the law, has been placed in the hands of the various states. It was intended to be not a federal but a state, and in its final analysis, a community program. That the states have undertaken to apply the law in the same spirit in

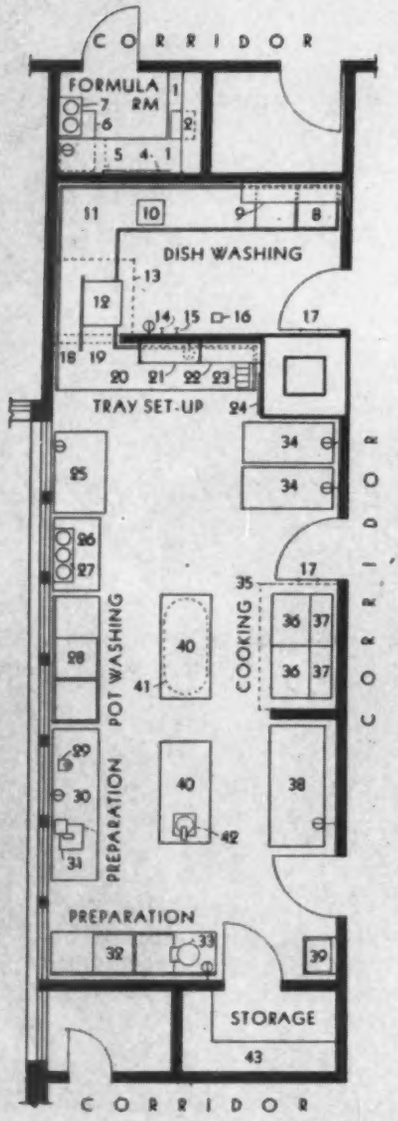


which it was enacted by Congress is revealed by the fact that almost three-fourths of the hospital projects submitted by the states have been in communities of less than 10,000 population.

On June 1, 1948, 214 applications for construction of general hospitals had been approved. Of this number, fifty hospitals were within the range of twenty-one to thirty beds. Since it is a responsibility of the Public Health Service under Public Law 725 to assist the states in every way in accomplishing the hospital program, this was an indication that guide material should be made available to the states and communities for use in measuring all advantages and disadvantages of the small hospital, and to assure the best return for tax money and other funds involved. Under the program, the federal government defrays one-third of the cost of construction with the other two-thirds being paid by the state or community.

Programs involving small hospitals, as submitted by the states, tend to follow fairly closely the pattern of hospital sizes in the United States. In 1946 the American Medical Association reported 4523 general hospitals. Of this number, more than 1200 were under twenty-five beds; almost 1400 between twenty-five and fifty beds.

(*Continued on Page* 52.)

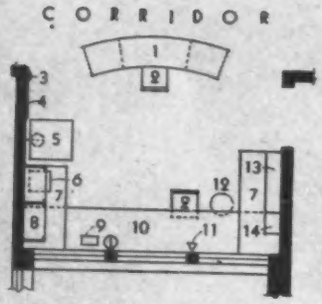


KITCHEN AND FORMULA ROOM

LEGEND

1. Counter 36 in. high, with cabinet below
2. Sink
3. Wall cabinet
4. Bulletin board 26 in. by 24 in.
5. Holder for formula record book
6. Milk cart
7. Hot plate, two elements
8. Double compartment sink 24 x 24 x 14 in. each
9. Shelf for soiled glasses
10. Pre-rinse sink
11. Soiled dish table
12. Dish washing machine
13. Hood
14. Cold water supply
15. Hot water supply
16. Floor drain
17. Vision panel
18. Rack return slot
19. Open pass window
20. Counter 36 in. high with open shelves below
21. Wall cabinet
22. Three shelves over
23. Silver compartment
24. Bulletin board 26 by 24 in.
25. Frozen food and ice cream storage
26. Utility table 2 ft. 3 in. by 3 ft. 8 in.
27. Coffee maker, vacuum type, three element
28. Double compartment sink and drainboard
29. Juice extractor
30. Preparation table 2 ft. 3 in. by 7 ft. 6 in.
31. Meat slicer
32. Double compartment sink and drainboard
33. Peeler 15 lb. capacity
34. Tray truck
35. Hood
36. Range with oven
37. Elevated broiler
38. Refrigerator 60 cu. ft.
39. Sink
40. Cooks' table 2 ft. 6 in. by 5 ft.
41. Pot rack
42. Food mixer
43. Shelving 18 in. wide, first shelf 36 in. above floor

0 4 ft
GRAPHIC SCALE



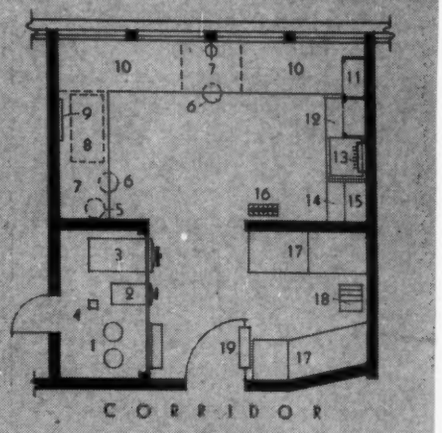
NURSES' STATION

LEGEND

1. Nurses' control counter
2. Straight chair
3. Domelight and buzzer set
4. Bulletin board
5. Refrigerator 6 cu. ft.
6. Medicine sink in counter with gooseneck spout
7. Counter 36 in. high with cabinets below
8. Locked wall cabinet with inner locked narcotic compartment & inside light
9. Hypodermic sterilizer
10. Counter 30 in. high, open below
11. Telephone outlet
12. Waste paper receptacle
13. Chart rack
14. Pigeonhole form rack

LEGEND

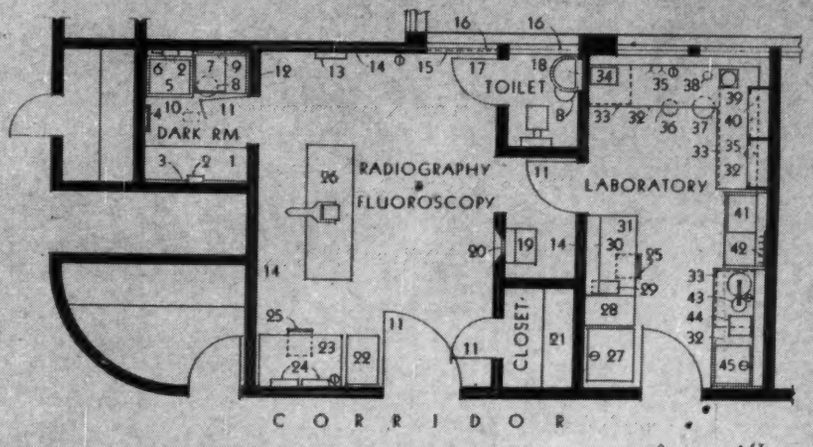
1. Water sterilizer, 15 gallons each
2. High speed pressure instrument sterilizer 12 in. by 20 in.
3. Dressing sterilizer (cylindrical), 20 in. by 36 in.
4. Floor drain
5. Waste Paper receptacle
6. Stool
7. Counter 36 in. high, open below
8. Supply cart
9. Bulletin board, 26 by 24 in.
10. Counter 36 in. high, cabinets and drawers below
11. Wall cabinet
12. Sink and drainboard
13. Multiple rubber tube washer
14. Counter 36 in. high, open below
15. Shelf
16. Glove drying rack
17. Sterile supply cabinets
18. Step ladder
19. Dutch door



CENTRAL STERILIZING AND SUPPLY ROOM

LEGEND

1. Film loading counter with cabinets, film safe & cassette storage below
2. Safe light
3. Film hanger racks
4. Towel bar
5. Developing tank
6. Timer
7. Sink with drainboard
8. Waste paper receptacle
9. Film drying bracket
10. Ceiling light, white & red
11. Lead lined door, light proofed
12. Light proofed louvers
13. Wall mounted cassette holder
14. Lead lining (size & extent varies)
15. Light proof shade
16. Obscure glass
17. Light proofed door
18. Recessed cabinet
19. Control unit
20. Leaded glass view window
21. Shelving
22. Film filing cabinet
23. Desk
24. Two view boxes on wall
25. Chair
26. Combination radiographic and fluoroscopic unit
27. Refrigerator 9 cu. ft.
28. Filing cabinet
29. Microscope
30. Book shelves
31. Table
32. Acid resisting counter
33. Cabinets below counter
34. Analytical balance
35. Air, gas, electric outlets
36. Stool
37. Sanitary, waste receptacle
38. Bunsen burner
39. Single element hot plate
40. Wall cabinets
41. Acid resisting laboratory sink
42. Peg board
43. Still, one gallon per hr.
44. Water bath
45. Hot air sterilizer



RADIOGRAPHIC AND LABORATORY ROOMS

Until a better distribution of hospital services is developed, communities will continue to build and operate small hospitals, even though they realize that costs are disproportionate or services are limited. An improved distribution for hospital services will require prolonged educational stimulation. In the meantime, without endorsing entirely the principle of the small hospital, the accompanying material has been developed to assist communities in their attempts to establish minimum necessary care.

Establishing a Community Hospital

The first action leading toward a community hospital is the establishment of a representative committee, including leaders in local business, medical and health fields, farm, labor and other groups. A small working committee should be selected. The committee should first call upon the official agency in the state which has been designated to carry out the program under the Hospital Survey and Construction Act. This should be done even though the local project may not benefit financially under the law. The state agency has made a study of hospital needs, and the local effort should be coordinated with the total state program. That agency can give much advice and assistance. The American Hospital Association, through its Bacon Library, is in a position to furnish guide material on community planning and hospital problems.

Local Needs

This article is not intended to recommend a twenty-five-bed hospital for any particular community or population group. It has been estimated that approximately 2.5 beds for each thousand of the local population would be sufficient for rural areas, but this may be more than the community can afford, and, in any event, the more complicated cases would have to be referred to a larger hospital. The need for new facilities can be determined only by a comprehensive study of local factors, including availability of other facilities, professional personnel, population trends, sickness rates, wealth of the community, and its hospital consciousness. When possible, the state agency will assist the community in obtaining the services of a hospital consultant to determine needs and to develop a written program. The consultant and the committee will work with the architect in developing and carrying building plans to completion.

Good hospital planning for such a small institution makes it vitally necessary for it to become affiliated with a larger institution. The quality of services which it may render can be markedly improved by consultation and affiliation with institutions having a larger and more specialized medical staff, better equipment, and more nearly complete clinical facilities.

The administrator should be employed as soon as possible in the planning stage. Savings, over his salary costs before the hospital begins operation, will be reflected materially in handling of details for the hospital committee; in selecting and purchasing materials and equipment; in developing policies, organizational, and administrative procedures; in selection of personnel; in fund raising campaigns, and in numerous other actions that will contribute to better planning, more efficient operation, and improved patient care.

Site Selection and Space Requirements

An architect, preferably experienced in hospital design, should be employed from the beginning of the program.

The site selected should be adequate for future expansion to at least double the initial size without crowding. A donated site often is found to be more expensive in the long run than is a site which is selected and purchased because of its desirability for hospital purposes.

Generally speaking, a hospital within the twenty-five-bed range can be administered more efficiently if facilities are on one floor. Consideration should be given to inclusion of space for local public health services and offices for private practitioners of medicine and dentistry. Such combinations tend to promote better community health services, eliminate duplication of equipment and space, and often help in the financial support of the hospital.

A common error on the part of the public is for it to consider a hospital as merely a house or building with beds. Even the smallest hospital is complicated, and its planning, organization and management affect to a marked degree the adequacy of patient care. In practically all instances, an existing building not designed for a hospital will prove to be too expensive to remodel and operate.

A Type of Facility

The design of the building will vary with local needs. The accompanying plan is given merely as a suggestion and probably would require considerable adaptation by the architect for a specific community. This also applies to equipment lists which are available.

Space requirements for the average hospital will total from 500 to 700 square feet per bed. The schematic plan illustrated has been condensed to what may be considered a practical minimum of 500 square feet for each bed. Functions have been combined and compromises have been made in order to accomplish this. The emergency room, for example, can be used both as a treatment room and for outpatient services. Dental services also can be provided here, although some feel that a separate dental room is preferable, where possible.

No separate medical record room has been provided but the space allowed in the business office is generous enough for this important function. The more important principles of hospital planning have been observed despite the size and condensation of certain areas. Concentration of the administrative, clerical and service units will permit a staff of limited size to operate efficiently and on an economical basis.

With these facilities, general medical, obstetrical, and minor and emergency surgical cases can be cared for adequately. Because specialized surgical and diagnostic services could not be offered here, patients requiring such services would be referred to larger hospitals.

Inasmuch as the major portion of total activities of the small hospital revolve immediately about it, the nurses' station has been located at the juncture of the two nursing wings to provide control of both corridors. Its relation to the business office and information counter allows the nurse on night duty to observe the lobby and to maintain control of the business office (when the clerical staff is off duty) without being isolated from her station.

The nursing units are well insulated from the street and service court. The maternity nursing unit has been given the south orientation and is separated from the other services—a highly desirable feature which is seldom found in the small hospital. The close relationship of the nursery to the ma-

ternity beds will save nurses' steps in transporting the babies to their mothers. A small formula preparation room has been provided, the formulas to be sterilized in the central sterilizing room. The utility room location makes it convenient to both nursing wings.

The surgical and delivery suites are located at a dead-end area and are separated from each other and the emergency room. Both these suites may be considered minimum. The proximity of the surgery and delivery room units to the lobby area may appear to be undesirable, but is probably the least objectionable of several compromises that must be made in the planning of any small hospital.

The relation of the emergency room to the lobby, although certainly not good practice in the larger hospital, is acceptable in the smaller institution where the volume of accident work is limited.

The service wing provides a minimum of storage space with a separate closet for the storage of equipment in general use. Clean linen storage in the service wing is separated from the main storage room. The soiled linen room allows space for a domestic washer for laundering soiled diapers; the rest of the linen would be done commercially, inasmuch as no laundry is provided in this plan.

The kitchen is conveniently related to the nursing wings for easy service of trays. It is sufficiently isolated to prevent kitchen noises from disturbing patients. A can washing room and tool room are placed on the loading platform accessible from outside of the building.

A boiler room has been placed below the kitchen although it may be at grade if conditions demand.

The central services will allow a limited future expansion.

The total gross area of the hospital, including the boiler room, is 12,500 square feet.

Construction Costs

The variation in labor and material costs in different localities makes it impossible to quote figures for construction that would apply to a specific community.

Hospitals of this type usually will be built in towns and smaller cities with moderate wage rates, and the natural tendency will be to assume that construction costs in such areas will be lower than they are in metropolitan areas with higher rates. However, consideration must be given to the fact that hospital construction work will require certain types of skilled mechanics and that most of such labor must be imported from larger cities. The cost of such imported labor will, in most cases, make the total labor cost of the project in small towns the same as that for projects in places with higher wage rates. Building materials and equipment will cost as much as they do in metropolitan areas, and often more, because of higher transportation cost and greater handling charges.

For the accompanying twenty-five-bed hospital, it has been assumed that the following average costs will be about the same for most locations in the states:

Building, including built-in equipment, contingency for minor changes in construction, and site improvements	$220,000
Furniture, medical equipment, kitchenware, linen and other movable equipment	39,000
Site survey and soil investigation	500
Drawings and specifications	13,000
Supervision and inspection at the site	3,000
Hospital consultant and other expenditures	1,500
Total project cost	$277,000

This average cost of $11,000 per bed is in accord with estimates from architects and contractors in all parts of the country; figures reported by them ranged from $9000 to $14,000 per bed.

More accurate preliminary construction estimates for a particular area can be obtained by having a local contractor submit estimates on the basis of the number of square feet per bed in the plan. He must remember that because of the unusually expensive methods, materials and equipment necessary in hospital construction, the cost will be higher than that for ordinary buildings in the area.

Operating Costs

Costs of operation for nonprofit hospitals with fewer than fifty beds in 1946 averaged $1908 per bed per year, or $8.24 per patient per day. Income from patients in these hospitals for the same period averaged $1752, or an average of $7.57 per day. More nearly complete data on this subject can be obtained from the publication "Evaluating Hospital Operating Costs" by Dr. Louis Block, as reprinted from the December 1947 issue of *Hospital Progress;* copies may be obtained from the various state agencies.

Experience indicates that occupancy of the average twenty-five-bed hospital will usually vary between ten and fifteen patients per day. Rate of occupancy directly affects operating income and the quality and quantity of services the institution can render.

Personnel

Salaries and wages constitute from 50 to 60 per cent of the total annual costs. The average twenty-five-bed hospital will require a minimum of from twenty to thirty employes if an adequate attainable standard of care is given. These would include the director, from six to ten professional nurses, an equal number of practical nurses and attendants, at least two clerical employes, a laboratory technician who might undertake combined duties, a cook and several kitchen attendants, an engineer and related employes.

Annual Supplies and Equipment

The total cost of supplies will average between $600 and $800 per bed per year, including raw food. Equipment purchases will average about $100 per bed per year. Thus, the annual cost of supplies and equipment will total about $20,000.

Laundry costs may be based upon an average of about ten pounds of laundry per day per patient. Ordinarily the twenty-five-bed hospital is not in a position to operate its own laundry, hence commercial prices should be obtained for from 100 to 150 pounds per day.

Light, heat, maintenance and repairs would require at least $150 to $250 per bed per year.

Thus, the twenty-five-bed hospital will be faced with a total operating budget of between $50,000 and $75,000 each year. Costs will vary with local salary scales and other items.

Good hospitals are expensive and cannot be easily compared with the ordinary business which is operated on a profit basis and not as a public service. While poor hospitals may be maintained for less money, in the long run they are more expensive in terms of patient welfare. The community should undertake the complicated procedure of planning and maintaining a small hospital only after complete study of the problems involved.

HOW TO GET ALONG WITH —OR WITHOUT—UNIONS

NORMAN D. BAILEY
Business Manager and Personnel Director
Lenox Hill Hospital, New York City

HOSPITALS present one of the almost entirely unworked fields toward which labor leaders may turn for recruitment and strengthening in the days ahead. To a small—a very small—degree hospitals are organized. To a great degree they are still filled with heterogeneous groups of employes with little in common except the fact of their employment. The union, in seeking to organize a hospital, must find some common element by which it can create unity in the group. In searching for this it will look first for causes of complaint.

A study of labor history indicates that unions came into existence because of the shortsightedness and greediness of management. Not even the sturdiest supporter of the capitalistic system can deny this. Individuals, failing as such to achieve their desired ends, sought to find a way out in seeking the ends as groups or unions. If management had been longsighted instead of shortsighted it would have eliminated the causes before the employes sought to take the situation into their own hands.

OTHER CAUSES FOR ORGANIZATION

There were other causes for labor organizations: the remote control of absentee ownership, the widening gulf between employer and employe owing to increase in the size of business, the influx of new levels of workers who were fertile soil for antimanagement propaganda. All of these contributed, but by and large the shortsightedness of management was the prime cause.

It is an interesting story—a story of advances and retreats, of rapid growth and repeated losses in membership. Today labor stands at one of those moments when it measures its strength, reevaluates its position and seeks to maintain ground already gained. Those who deal with labor must be cognizant of the fact that the let-up in pressure for more advantageous positions is only temporary.

My first proposal is that if management—in this case hospital administration—is to get along with unions it must know to whom it is talking and with what it is dealing. It must recognize that union leaders on the whole are shrewd, competent men fully the equal in ability of those who speak for administration. There are those who provide evidence for the belief that union leadership is bad, unethical and unrecognizable. There are also administrators who are no credit to their profession.

Union leaders have come from three groups. There have been those who are professional reformers—evangelists of change. They are a temporary phase of union leadership, and having served their end as agitators and recruiters they pass from the scene. They are followed by one of two types: the leader who possesses powers to lead but is primarily interested in self-aggrandizement, or the relatively conservative and factual individual who is anxious to see the union established on a respectable working basis and who knows that rabble rousing is temporary. In increasing numbers the latter group has developed the field of union leadership into a profession — well schooled and well disciplined, competent and versed in economics and business organization.

The 1948 version of a union leader has some actual job experience behind him. As one business agent who sat in my office recently said: "I don't want ever to get to the point where I can't be welcome if I put on overalls and start a day's work along with the gang." The actual work experience is a vital part of his qualifications.

In addition to that work experience, today's union leaders have a background of training in labor relations, psychology and business administration. Courses for the training of labor leadership have been developed and form a definite part of the fortification which the labor leader brings to you. He understands when and where it pays to pound the table, when it pays to be persuasive, when the simple facts are sufficient evidence to justify the appeal.

My second suggestion for getting along with unions is that we study our employment picture to make sure that the conditions under which our employes work are not such as to cause the employe to turn to the union or to any other possible outlet for relief. I am sure that in no one hospital are all of the conditions true, but some of them apply at least to every hospital. To that degree to which we are free from the problems I shall mention are we also free from the position of furnishing to union leadership the best possible ammunition for its campaigns.

STANDARD WORK WEEK

1. Occasionally I find a hospital in which the working week is in excess of the standard working week of the community. This in itself is serious, especially when coupled with the fact that like all service industries hospitals are compelled to operate on days and at hours when the greater part of the population is free for recreation or rest. It is difficult to justify a forty-eight-hour week when the standard working week in the community is forty hours.

2. Then once in a while I hear someone say that hospitals cannot afford to pay a standard wage. I shall have to add my own thought and that is that we shall get about what we pay for. If we buy substandard service we cannot expect to receive outstanding skill and superior production. There are exceptions, of course. There is the factor which I shall not attempt to discount, *i. e.* that there are people who in exchange for a feeling of security are willing to work for less. That is especially true of the older employe. As long as we pay wages below the accepted standards we offer an excellent basis for union organizations.

3. A few days ago I came in contact with a hospital in which employes reported that they "never knew just what day they would have off." Such a policy would not stand the test of industrial practice. The whims of his superior

From a paper presented at the Tri-State Hospital Assembly, 1948.

Hospital administrators might just as well get used to the fact that ignoring the existence of unions won't make them go quietly away. It is better to learn to deal with them on the basis of reason and good sense

cannot dictate the employe's work schedule.

4. Management in the late 1890's passed through what is generally called the paternalistic period — when, in order to ensure employe loyalty, it attempted to enter into his personal life and to bring to him benefits which it had decided would make his life more liveable. In some cases these benefits were resented because of the paternalistic patronizing attitude behind them. We know that employes who are given full maintenance as a condition of employment are financially better off in today's world, but in spite of this, in most cases they prefer a cash salary. Management moved away from the paternalistic philosophy along about 1910; institutions have, all too often, remained with it. One of the conditions of union argument is for elimination of perquisites.

BENEFITS FOR MORALE

5. Failure to recognize that industry and business have introduced many benefits not as substitutes for wages but to develop a higher employe morale will bring unfortunate comparisons of working conditions between other local industries and the hospitals. May I enumerate a few of these: (a) rest periods; (b) paid vacations; (c) pension plans; (d) adequate rest rooms; (e) recreation programs; (f) fairly administered promotion plans.

When programs such as these are fairly administered we have gone a long way toward developing "the happy well adjusted employe" whose grievances will be few and whose production will be high.

My third suggestion for getting along with unions concerns the training of supervisors in human relations. The first-line supervisor, who represents the administrator in relations with employes, is an important figure. How much does this supervisor know about the policies and principles that govern the relationships between the top levels of organization and its employes? All too often this supervisor has been left out in the cold. Here she is; by her position she is the interpreter of your policies to others. How much have you done to give to her the right point of view toward the problems at hand? The problem is far more serious than at first it seems.

An old philosophy that the best background for supervisory capacity was excellent workmanship led us to take either the oldest or the best worker and make him or her a supervisor. Such selections proved unsatisfactory, for supervisory ability depends upon far more than age or work experience. It involves the ability to lead and to direct human beings. Age itself—seniority, if you will—is no indication of supervisory ability. Experience may be, but it must be supplemented by training in the more important skill of handling people.

Why do I stress this? Because the supervisor is the logical first step in the grievance procedure. It is here that employer-employe relations fail or succeed. Moreover, production and turnover are both related to the ability of the supervisor. Lowered production and high turnover result from poor, inadequate supervision. These in themselves lead to dissatisfied employes—the most fertile soil for union propaganda.

Employes do not want supervisors for whom they must daily "polish the apple." They do not want to be groveling, seeking favors, or subservient. They want fairness. They will respect firmness if it is consistent. They work better when they know that the supervisor will consider all the facts. Such a supervisor will make decisions only in the light of all the evidence. He will know no favorites except those who give adequate production in return for a day's pay. He will have the confidence and deserved loyalty of his fellows on the job. Moreover, he will be the key to fine employe relations.

How do we get such supervisors? They come through careful selection, through adequate training, and through channels of communications which give them their rightful place in the hierarchy of the employment pattern.

My fourth suggestion is an awareness of facts of the situation. Through his personnel director, other designated official, or his own efforts the hospital administrator must be constantly in touch with the actual conditions of employment, financial and otherwise, of both the hospital industry and industry as a whole in the area. Rest assured that the union business agent who calls on you is adequately armed with this information

The administrator cannot meet the situation with data even a month old when the facts across the table are of the current moment. For this reason, if for none other, a hospital of more than 300 employes should consider seriously the need for a specialist in the personnel functions. Here is a field which needs such ability and one in which the administrator may not be thoroughly trained.

WHEN HOSPITAL IS ORGANIZED

Let us turn for a few moments to the hospital which is already organized and consider the problem of getting along with the organization. Briefly, I am listing several principles which I believe will govern successful and harmonious relationships.

1. Know thoroughly the principles under which collective bargaining operates.

In the report and recommendations of the Twentieth Century Fund's "Study of Trends in Collective Bargaining" occurs this statement. "Collective bargaining is a trinity of economic wants, political presure, and psychological urgencies, the one acting reciprocally upon the other." The study sets forth certain principles.

"In the effort to have something effective to say about the setting of a wage, and to achieve higher living standards amid the ever changing environment of U.S. industry, workers have sought to replace the individual bargain with the group or collective bargain. By trial and error, they have discovered that to serve their own best interests they would have to stop competing against each other, and act in concert. Only in this way could they obtain some measure of control over the labor supply.

"They have observed, moreover, that the employer could readily discharge Bill Smith if he objected to existing arrangements; but if ten or a hundred or a thousand Bill Smiths joined together in a union and could threaten to withdraw their labor power simultaneously, the employer could not dis-

charge them all, without risking serious loss. By pooling their ability to work, by submitting to the discipline of their own group, in which they had voice and vote, workers have learned that they could counterbalance the employer's exercise of complete authority. They could pay their own officials to spend time to keep in touch with conditions in other plants, to acquire knowledge of the industry and of labor's legal rights; to guide organizing activity, to conduct negotiations with skill and insight. They could even hire other specialists, such as economists, lawyers and publicity men. They were thus equipped to deal with employers on a plane of greater equality. Quite as important, unionism endowed them with a new sense of dignity, of status, of counting as human beings. Every step that served to democratize plant procedures would extend their franchise as citizens of industry."

2. In collective bargaining—union relations—be sure that some one of those who speak from management's point of view understands fully the actual working conditions and problems under consideration. First hand knowledge and information are essential.

3. Throughout the organization adhere strictly to established grievance procedures. Any grievance, however small and seemingly petty, may be important to the individual involved.

4. Once an agreement has been established, accept it and don't attempt to undermine it. To keep an atmosphere of fair, above board dealing is important.

5. Facts which bear on the situation must be clearly presented. This becomes particularly true when demands are beyond the "ability of the hospital to pay."

6. Legal backgrounds and controls in employe relations should be thoroughly understood by the administrator. State laws vary and must be known before contracts are entered into.

In 1947 Congress passed a new version of the National Labor Relations Act. For hospitals it was significant because it put in words an unwritten policy of the National Labor Relations Board. It specifically exempted not-for-profit hospitals from the provisions of the act. This, however, is not an entirely unmitigated blessing for in exempting hospitals from its requirements the act also exempted them from its protection. For those private hospitals which come under the act some benefits have accrued.

The closed shop is outlawed. Supervisors are removed from employe status. Unions are liable to unfair labor practices. Unlawful boycotts and jurisdictional strikes are prohibited. One interesting minor detail is that "The N.L.R.B. cannot decide a bargaining unit as appropriate if it includes professional and nonprofessional workers unless the professional workers approve it."

7. The technics of contract writing call for special training and experience. The advice of a qualified attorney is called for at this point. A little money expended for his services may save much in the days to follow.

In dealing with any union situation I am inclined to think that a hospital in any given area should be influenced by several factors.

1. The general industrial situation in the area as far as unionization is concerned.

2. As a member of a hospital council or association in a given area the hospital has a responsibility to its fellow members and cannot fairly make its decisions without considering others.

3. The degree to which the organizing group represents the employes should be accurately determined.

4. The general point of view of the institution's patrons toward unions may have some bearing on the question.

5. To a large degree the hospital has to work within a fixed budget. Organized labor must recognize this fact.

SET UP EMPLOYE COMMITTEE

One final suggestion: most hospitals are not organized. In those that are not, what does the administrator know of the attitudes, problems and desires of the workers? An experiment has been in progress at Michael Reese Hospital in Chicago for some two years with an employe representation committee. This particular committee involves nurses only, but the plan could be extended. It is felt that the frank discussion evoked by the plan has borne fruit in better understandings, in problems solved, and in the general morale of the nursing group. A well developed plan of employe representative committee is an excellent technic for avoiding unionization.

Good relations with employes, as well as with unions, are the result of a long period of growth. They do not come all at once. They can be destroyed quicker than they can be developed. Continued cultivation through demonstrated fair play and mutual understanding will mature into excellent relationships.

Does it not all sum up in a recognition of a fair day's wage for a fair day's work under good working conditions with recognition for employe accomplishment?

Caring for Oregon Flood Victims

I WAS notified personally by the Red Cross that the dike of the Columbia River protecting the large and important government housing project at Vanport had broken. Unfortunately, this dike was regarded by engineers as safe. Consequently, inhabitants of the area were notified as late as noon on Sunday, May 30, that there was no cause for worry. At approximately 4:30 o'clock that same afternoon a whole section of the dike gave way, and it is my understanding that the water pouring in reached almost tidal wave proportions. Many of the flimsily constructed apartment buildings collapsed, either from the sheer force of the water or from crashing into one another.

At the hospital, we immediately recalled all key personnel to duty, including the intern and resident staffs, operating room and x-ray staffs and nursing personnel. We set up three emergency wards in our nurses' classrooms. These, fortunately, are adjacent to our main building and connected on the first floor.

We were quite busy during the evening. Our biggest influx of casualties was between 7:30 and 8:30 p.m., during which time we received approximately twenty-five patients—a few seriously injured. The majority were treated for shock, minor abrasions and exposure. During the course of that night and the next day we treated, in all, about seventy patients.—PAUL R. HANSON, *administrator, Emanuel Hospital, Portland, Ore.*

You can afford

TERMINAL STERILIZATION OF FORMULAS

just use the autoclave you already have

ROBERT H. LOWE, M.D.
Assistant Medical Director
Rochester General Hospital
Rochester, N.Y.

"AN AUTOCLAVE for the formula room? We can't afford it!" You can afford it because you already have it. Virtually all of the recognized hospitals in the United States have a pressure autoclave. A large percentage of hospitals have 100 beds or less with an average daily delivery rate of five or under. The purchase of a separate autoclave for the formula room would be unwarranted. Why not use the autoclave in the operating room suite? There it is only working a maximum of eight hours a day—sixteen hours of lost motion. Why *should* you buy another autoclave to process infant formulas for from one to four hours when you have an idle machine?

You say the temperature is set for 250° F. but that 230° F. is recommended for applying terminal heat to infant formulas. True—but if you will manipulate the steam vent valve as illustrated in figure 1 you can obtain the desired temperature of 230° F. In short, at 250° F. the vent valve is closed (figure 1, dotted arrow). In order to obtain 230° F., as the steam enters the autoclave, the vent valve pictured in figure 1 is turned back (partially opened) until it assumes the position shown by the solid arrow. Figure 1 is schematic only. Actual distances represented by arrows must be determined on an individual basis.

In the event the autoclave in your hospital is regulated by electrical controls, it is recommended that you seek the advice of the manufacturer. Do not hesitate, because experience has shown that it involves no expense or mechanical changes to alternate back and forth between 250° F. and 230° F.

The attention of the general public has been focused on the preparation of formulas for the newborn since an article recently appeared in a popular pictorial magazine. Formula preparation problems have been paramount in the minds of hospital administrators, pediatricians and obstetricians long before public attention was invited to them. Much worthy investigation has been conducted and many articles have been written about the problems. So much has been written that it is feared that the salient points in formula preparation have been camouflaged in verbiage.

These salient points are outlined below. All of these points have been substantiated by approved bacteriological and chemical analysis. Similarly, they have been found practical by actual operation. I will be only too glad to explain in detail any of the following points which may seem startlingly brief.

Objective: To produce formulas that are free from pathogenic bacteria, using *clean* preparation and compounding technics, followed by the pressure method of sterilization:

Preparation and Processing Technics

1. Personnel of average intelligence possessing the following qualifications can be trained by either a nurse or a dietitian in two or three hours: (a) ability to read and write; (b) knowledge and practice of good personal hygiene; (c) willingness and ability to follow instructions.

2. Minute-by-minute supervision by dietary or nursing personnel is not necessary when competent employes have been trained.

3. A cap to enclose the female superabundance of hair is advised. Aseptic technic cannot be observed. Practically, therefore, masks, gowns and gloves are redundant.

4. All bottles, nipples, and protective nipple covers should be rinsed grossly clean immediately following use in the nursery. This may be done by any employe available at any hour of the day.

5. All bottles, nipples and protective nipple covers should be washed grossly clean with a detergent solution immediately prior to filling and assembling. This may be done either in the anteroom of the formula compounding room or in the utility room of the nursery.

6. Grossly clean bottles, nipples, protective nipple covers, and mixing equipment may be grouped in the

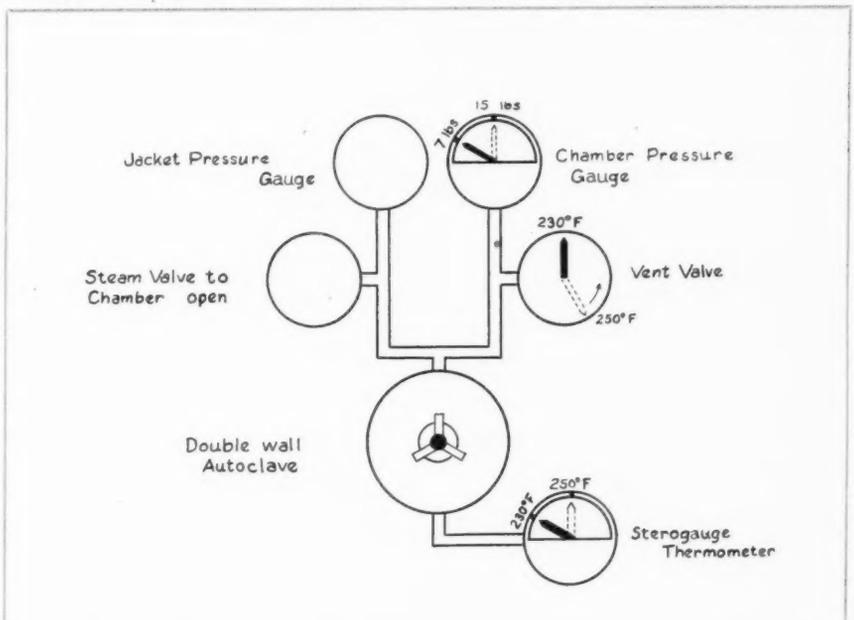


FIGURE 1. Solid arrows show position of indicators when vent valve is partially open: Dotted arrows show position of same indicators when vent valve is closed.

Schematic drawing showing how autoclave can be adapted for formulas.

Comparison of Two Methods of Formula Preparation

Formula, Equipment and Compounding Methods	Nonpressure Boiling Water Method—212° F. for 30 Minutes	Pressure Method—230° F. for 5 or 10 Minutes
1. An accredited source of ingredients	Essential	Same
2. Grossly clean equipment	Questionable sterile end results	End results sterile
3. Personnel attired as for a major operation	Indicated	Not necessary
4. Personnel without constant supervision	Questionable end results	Certain end results
5. Formulas—highest temperature of	210.5° F.—never reached 212° F.	229° F.—above 212° F. for 12 minutes using a 5-minute cycle
6. Nipples—highest temperature of	206° F.	222° F.—above 212° F. for 12 minutes using a 5-minute cycle
7. Cooling	Immediately necessary	Not necessary
8. Bacteriological content of formula if not cooled after processing	Growth at end of 24 hours' incubation exceeded allowable standards	Sterile at end of 5 days
9. Spores		
C. Tetani	No growth	No growth
C. Welchii	No growth	No growth
C. Botulinum	Growth	No growth
10. Ingredients—physical and chemical composition of, after processing	No demonstrable change	Same
11. Total processing time	40 to 45 minutes	18 to 22 minutes

formula room ready for filling and assembling.

7. Cans containing evaporated or condensed milk, dried milk powder, or other ingredients may be opened without special preparation if the compounded product is subjected to terminal heating under pressure.

8. The assembled formula unit consisting of bottle, formula, nipple and protective nipple cover is then subjected to terminal sterilization in a pressure single wall autoclave at 230° F. for five minutes, or ten minutes if a double wall autoclave is used.

9. Formulas subjected to this method of terminal sterilization do not have to be rapidly cooled in order to prevent the recurrence of bacterial growth. Formulas processed thus are sterile at the end of five days' incubation at optimum growing temperature.

Previous temperature experiments have been restricted mainly to the temperature resulting in the formula. Considerable speculation has arisen as to the temperatures the nipples reach; after all, this is the portion of the unit that comes in intimate contact with the baby.

Recent experiments with the protective nipple cap tightly applied have disclosed the following:

1. Temperatures inside and outside the sucking portion of the nipple when heated in a boiling water nonpressure sterilizer reached 206° F. nine minutes after the water started to boil and remained there for the duration of a twenty-five-minute cycle.

2. Temperatures inside and outside the sucking portion of the nipple when terminally sterilized under pressure for five minutes at 230° F. were 213° F. one minute after the autoclave reached a temperature of 230° F. and ascended to 222° F. at the end of a five-minute cycle. Furthermore, the temperature remained above 212° F. for an eight-minute depressurizing interval. In short, the temperature of the nipple was above 212° F. for twelve minutes.

There has been considerable speculation also as to what happens to anaerobic spores if terminal heating at 212° F. and 230° F. is used. Formulas were heavily inoculated with Clostridium Tetani, Welchii and Botulinum. Cultures taken of formulas heated for thirty minutes in a boiling water sterilizer showed growth of Clostridium Botulinum, "food poisoning," the most dangerous of all spores. Cultures taken from formulas similarly inoculated and subjected to terminal heating in a single wall pressure autoclave at 230° F. for five minutes were negative for growth of all of the three types of spores.

MAY USE POWDERED TYPE

Mention has been made in previous articles of the fact that liquid lactic acid must be added to the formula after the formula has been subjected to terminal heating because coagulation and nipple clogging will result if it has been added before. This opens wide an avenue for contamination. Powdered lactic acid may be substituted for the liquid form and subjected to the heat of the pressure method of terminal sterilization to eliminate this problem.

In summary, therefore, a comparison between the two popular methods used today is offered in the accompanying table.

Conclusion: The formula may be eliminated as the infecting agent in epidemic diarrhea of the newborn when terminal sterilization is applied using the pressure method for from five to ten minutes at 230° F.

Quality Control of Purchasing

The principles set forth by the author have just one aim: to simplify the purchasing function

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THE critical shortage of hospital beds plus the increased use of hospital facilities has unleashed a hospital construction program unparalleled in the history of hospital operation. The result of this activity will be the greatest movement toward modernization of plant that we have ever known. In line with this development, we must now prepare to streamline the purchasing procedures of the departments that will be charged with the responsibility of furnishing the supplies and equipment to maintain these new plants and keeping service on a level with facilities.

CONSIDERED NECESSARY EVIL

In too many hospitals purchasing is one of those jobs that is considered as a necessary evil and is not given the thought and consideration it deserves. Industry has long since learned that scientific purchasing is a major factor in the management function, and we may follow in its footsteps to our profit.

Although dollars saved is not the only measure of good purchasing, it is at least a convenient standard of measurement. Inasmuch as it can best be expressed in terms of gross expenditure, we can get some idea of what can be done by examining recent figures on supply costs.

The Duke Endowment "Year Book" for 1946 lists total operation expenses of $26,791,889 for 132 general hospitals in North and South Carolina. Of this amount, $11,617,742, or 43.36 per cent, was spent for supplies and equipment. Assuming that this ratio may be extended to the national scene, our supply cost is nearly 45 cents out of the hospital dollar. Surely, at this high level, we cannot afford to do a poor purchasing job.

Good purchasing is, in the final analysis, merely a matter of establishing a series of controls—control of quality, control of quantity, control of inventory, control of salvage, and control of records. Certain basic principles are necessary to setting up such controls. These principles are guideposts to sound procurement and form the framework around which a progressive program should be built.

Several years ago, one of the largest industrial firms in the United States issued a pamphlet called "Purchasing Procedure and Regulations," which stated:

"Quality is the first principle of good buying and the most important. It takes this position because proper quality is a necessity of company product performance, and, at the same time, the degree of quality specified has a direct relation to cost. The highest quality is not intended but only that grade or degree which will fulfill, but not exceed, the requirements for which the goods are intended."

The final sentence of the quotation is an excellent statement of the primary principle of quality control. We must first determine what quality we need, by setting forth the essential factors. These factors will vary, of course, among items and among institutions, but those common to all are: efficiency in use, durability, and ease of installation and repair.

The quality which is needed having thus been determined, it must be stated on purchase orders and contracts in clearly understandable terms. Such a clear statement of requirements gives the vendor definite knowledge of what he is expected to furnish and affords a sound basis for fair inspection when the merchandise is received.

Specifications may be written by a number of methods. Those most commonly used in the hospital field are:

1. By brand or trade name.
2. By identification with a standard specification.
3. By description of purpose or use.
4. By sample.
5. By use of approved vendors' lists.

Caution should be exercised in the use of the first of these methods. The usual practice in specifying by brand is to add the words "or equal" following the stated trade name. This implies a willingness to accept other than the brand specified and ability of the buyer to determine whether or not a substitute brand is the exact equivalent of the one originally specified. This method is most unfair to our suppliers, unless we are prepared to accept these implications as fact. In most cases, the use of the "or equal" is merely a salve to the buyer's sense of fairness, and he has no real intention of accepting any substitute brand. If that is the situation, why waste his time and that of several suppliers in handling bids which will never be considered?

OTHER METHODS ARE BETTER

The other four methods listed are much more satisfactory from the standpoint of both buyer and seller. They are more easily understood, more precise, and offer less opportunity for erroneous interpretation. All specifications should have certain essential characteristics if they are to be of any value. These are as follows:

1. They should be clear and simple. Involved and complicated phrasing, unnecessary words, and useless repetition cause misunderstandings and tend to increase costs.
2. They should be capable of being filled with standard merchandise. This will promote economy without limiting quality. Special manufacture is almost always expensive.
3. They should be open to competition. Limitation of competition tends to increase price.
4. They should be reasonable and flexible. Specifications which are more precise than is necessary add to cost and limit competition.
5. They should be capable of being

checked. The proposed method of testing should be included in the specification. If it cannot be checked, it is useless.

Determining the proper quantity to purchase is a matter which requires considerable study because of the number of factors that affect such a determination. Because stocks are carried on many of the items which are bought in the hospital, quantity control and inventory levels are almost inseparable, and both are largely dependent upon the rate of usage. This is the primary consideration in arriving at the proper buying quantity.

Other important factors are quantity discounts, storage facilities, rate of deterioration or obsolescence, market trends, the cost of replacement purchases, cost of storage, and time required for delivery. Industrial purchasing agents, in attempting to solve this problem, have even developed mathematical formulas as a means of determining proper quantity. These are accurate as far as they go, but it is impossible to develop a formula for the hospital where supplies purchased are for consumption rather than production, and where usage may be extremely variable.

TWO FACTORS IGNORED

Most of the factors listed are self-explanatory. Two of them, however, are frequently ignored. These are the cost of storage and the cost of purchasing. The multiplying factor for the cost of storage that is oftenest used is 11 per cent and is based on 6 per cent interest on investment, 4 per cent for taxes and insurance, and 1 per cent for deterioration and obsolescence.

In determining storage cost, this percentage is applied to the dollar value of average stock, *i.e.* if the normal purchase of an item is $500, and this is a year's supply, it is assumed that stock level will vary between that amount and zero, and the cost of storage is then 11 per cent of $250, or $27.50. If it comes to the attention of the buyer that by ordering $1000 at a time instead of the normal $500 he can get an additional 5 per cent discount, he has a sound basis for determining whether or not such a course is sound business. In the case described, since the total discount would be $50 and the cost of storing the additional stock is $27.50, it looks like a good investment.

The cost of purchasing is determined by dividing the total cost of the purchasing function by the average number of purchase orders issued. This establishes a definite cost of issuing a purchase order.

We now have a check as to the most economical quantity to buy, because it is obvious that the lowest possible cost has been obtained when the cost of issuing an order is equal to the storage cost for the quantity ordered.

As stated earlier, many of the considerations that affect inventory control are the same as those which determine quantity control. There are, however, some principles which are strictly inventory matters. These concern methods of issue and storage, allowances for changing demand, and establishment of minimum and maximum quantities.

When new hospitals are built, or new storerooms are designed, the space and equipment provided can be planned to fit the types and quantities of merchandise which are to be housed. Unfortunately, most hospitals are forced to adapt their storage to present conditions and do not have the opportunity to meet this problem squarely. Under these circumstances, the handicaps are often almost insurmountable. However, whether the facilities are good or bad, much labor time can generally be conserved by a little study of the items to be handled.

Study of supply requisitions will bring savings in storeroom operations. The number of requisitions that must be processed should be limited in order to reduce paper work. This can be done by staggering issue days for the various departments of the hospital and by setting time schedules so that the flow of work in the storeroom is as even as possible and allows time for daily posting of completed requisitions.

Supplies should be issued, as far as possible, in standard units, preferably in the units in which they are normally purchased. This makes for easy accounting on inventory records and tends to avoid error in counting items.

Merchandise should be located in the storage area in accordance with the frequency of demand. Such items as printed forms, which are issued often, should be most accessible to the storeroom personnel, while merchandise which moves more slowly can be located in the more remote portions of the area. Small items should be placed in drawers or bins. Heavy case goods should be accessible to hand trucks for easy moving and should be so placed that they do not interfere with normal traffic in issuing other items.

In establishing minimum and maximum quantities on stock, care should be exercised to allow for peak loads and seasonal demands. Too often, inventory limits are based on straight averages without taking these variations into consideration, and an insufficient spread is allowed in determining averages.

Many inventory systems break down periodically through lack of cooperation of other departments. The storekeeper should be the first one to be notified when changes in standard items are contemplated by any department. This allows him to let stock run down on the item to be discontinued and serves to hold obsolescence to a minimum. When changes of this kind are made, every effort should be made to use the current stock of the replaced item before the new one is placed in service.

CENTRALIZE SALVAGE OPERATIONS

In order to control salvage operations, it is important that they be centralized under the jurisdiction of one responsible individual. Inasmuch as items which are surplus as to one department may be in demand by some other department, this control is best exercised by the buyer, who is cognizant of the needs of all departments of the hospital.

Control of salvage operations necessitates extensive efforts toward economical repair of damaged and worn-out equipment, and this is generally recognized. One point of loss, however, is that, frequently, items that cannot be repaired are sold at nominal amounts to employes or others, without consideration of the fact that component parts of the item sold may have greater value for use in future repairs than the amount received by direct sale as a whole.

Salvage opportunities are often missed in the handling of small expendable items. Many of these, when they have outlived their original purpose, can be returned to the storeroom for reissue to other departments for other uses.

Savings can many times be realized in this field by the simple expedient of considering the salvage possibilities of supplies and equipment when they are originally purchased. Frequently, the original cost of two competitive items may be approximately the same, but the future advantages of multiple

use may add greatly to the utility of one of them and serve materially to reduce its overall cost.

The principle of good record control is of prime importance in establishing a good purchasing system. Too often, while the records used are adequate, they require far too much clerical time to maintain them in a current status.

Consideration of all records used from the standpoint of the value of the information they contain is often enlightening. There are three cardinal rules of good record control, and no record can be worth while which does not comply with these rules:

1. The form must be simple and easy to post.
2. The information contained must be essential.
3. The form must be so filed that it is readily accessible.

Forms should be so designed that they will do double duty, whenever possible. In this connection, here are a few suggestions for improvement of record systems:

1. Inventory record cards can be used as floating requisitions for stock replacement.
2. By redesigning the form, the same card may be used for both inventory and purchase record.
3. Most forms can be made up in a standard size for simplification of filing.
4. One extra copy of a purchase order can be used as a receiving report.
5. One copy of the supply requisition can be used as a storeroom charge-out slip.
6. Follow-up copy of purchase order will also serve for back order file.
7. Extra copies of purchase orders and requisitions can be used to do away with requisition and purchase order registers.
8. Inspection and receiving reports can be combined.

All of the foregoing principles are aimed at a single goal—the simplification of the purchasing function. Simplicity is the heart of sound business operations. Every procedure should be critically examined for wasted time, wasted material, and wasted effort. Complicated systems and procedures may be impressive, but they lead only to errors in operation and require excess personnel.

The easy method should never be sold short! In the final analysis, it is almost invariably the most economical and serves best the hospital goal of maximum service at minimum cost.

A PATIENTS' LIBRARY

Is Worth the Time and Trouble

MRS. HARVEY L. STREET II

Chairman, Patients' Library
Nassau Hospital, Mineola, N.Y.

THE patients' library of the Nassau Hospital, Mineola, N.Y., was reinstated last spring after being inactive for several years. This is a complimentary service sponsored by the women's auxiliary and is maintained by special donations that make it possible to obtain the latest novels through the various book clubs which favor us with institutional rates.

We started our project with a special donation of $100 and have money left from that original amount after functioning for almost a year. Waiting rooms and solariums are supplied with current magazines which are turned over to us by various members of the auxiliary and their friends. As an added service, cigarets, penny postcards and stamps are sold to the patients.

CREATES GOODWILL

Three days a week, every bed in the hospital is visited, and the days chosen are those which are not regular visiting days. From our office in the basement, two volunteers start off together, pushing the special book cart on their rounds through the entire hospital. Not only is this service greatly appreciated by the patients, but often in the course of conversation a petty complaint is mentioned and it is possible to relieve the patient's state of mind by referring his complaint immediately to a member of the hospital staff, who, upon inquiry, usually learns that the patient has been misled or misinformed in one way or another. Thus, the staff member is able to satisfy many a patient still in the hospital and create a feeling of goodwill rather than dissatisfaction.

Last Christmas the volunteer "librarians" met and made up attractive, small corsages of evergreens and berries tied with gay red ribbon. Three packages of Life Savers were bundled together with greens and ribbons, and packages of the most popular cigarets were tied up in the holiday manner. The afternoon of the day before Christmas we put these gifts on our cart and distributed them among all the patients.

My co-chairman and I were the fortunate ones who took the book cart around on that day. It certainly "did something" for the patients and it was a great joy to us to help spread Christmas cheer. We were asked by one patient to "please sing Christmas carols," but we could not accommodate her, neither of us being able to carry a tune! On our rounds through the hospital it suddenly struck us as rather funny to be handing out "Life Savers."

Our volunteers are trained to recognize easily those who are too ill to read and wish to be left alone, but at a later date these patients are interviewed and they receive us most enthusiastically. We, of course, never mention the patient's illness but I shall never forget the one who asked me if I knew what was the matter with her. Receiving a negative answer from us, she said, "Well I'm here because I have a 'culinary thrombosis'." I believe many women have that disease but we will never land in the hospital with it!

We are greatly encouraged in our work by the cooperation given us by the nursing staff on each floor of the hospital and we sincerely appreciate their interest in our library service.

I am convinced that if there is any women's auxiliary group that has not already sponsored a patients' library in its own hospital it would be more than repaid for the time and effort spent for this most worthy cause.

LINEN STAINS GO DOWN THE DRAIN

an automatic washing machine in the utility room saves nurses' time and mitigates a distasteful job

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HOW to handle stained linen from surgery and the delivery rooms without wasting a high percentage of nursing time has been a serious problem in the small hospital. Some hospitals have required their nurses to prerinse all stained linen before it is sent to the laundry. Others have set up definite schedules for the laundry employes and have required that they pick up all stained linen and take it to the laundry for separate handling.

Still other hospitals have installed soaking tubs in their utility rooms, and the linens are removed at night and taken to the laundry to be washed the following morning. All of these methods are extremely annoying and consume a number of nursing and man hours each month.

Our solution to this problem was simple. When we planned a new utility room on the obstetrical floor, we included a space for an automatic washing machine. All linens from the delivery rooms are given a cursory inspection for the removal of large blood clots and are then thrown into the washing machine and go through the washing cycle in warm water. This method is very satisfactory, and we have found that so long as the machine is not overloaded, small stringy blood clots will be disposed of during this routine washing.

Diapers from the nursery also create a very distasteful problem, and most hospitals must require that their nursery attendants prerinse the heavier stools from the diapers before they are sent to the laundry.

Diapers from our nursery receive no prewashing attention. However, we do add soap, and we do raise the temperature of the water. In no instance has the machine failed either to dispose of the stools entirely or to prepare the diapers adequately for laundering. It should be remembered that we are not recommending that this procedure be used in lieu of laundry service. We are recommending only that the machine be used to prepare the linens and diapers before routine processing in the laundry.

We have estimated that this machine is now saving us approximately one half hour of nursing time for each delivery. In the nursery, with an average infant load of ten, we estimate that we are saving approximately one hour and a half of nursing time during each twenty-four-hour period.

It is not the intent of this article to endorse a specific make of automatic washer. Experimentation with a number of machines, however, disclosed the following guides that should be followed in the selection of any automatic washer:

1. The machine should open from the top to eliminate unnecessary stooping.

2. Machines that require a sealed door for operation are hazardous, in that personnel may become negligent. An unlocked door means a flooded utility room.

Stained linens from the surgery, nursery and delivery room go through the washing cycle.

3. The opening into the tub should be large enough to accommodate heavy gowns and sheets.

4. Machines with small hooks or gadgets around the opening are not recommended. They are extremely hazardous to the linen, as well as to the personnel.

5. It should be possible to operate the machine without closing the door. A machine that creates heavy splashes will also create a sloppy utility room.

6. It should be possible to set the washing cycles and fix them in such a way that the personnel cannot interfere. The less control the personnel has over the operation of the machine, the better.

7. If the machine is to be used for a dual purpose, such as diapers and linen, then a manually controlled temperature mechanism is necessary.

8. If the machine is to be used for diapers, it should contain an agitator. This is a matter of opinion, but we feel that the stools are more rapidly dissolved in a machine of this type.

9. The noise and vibration created should be definitely considered.

10. The machine should be purchased from a local dealer who is able to furnish immediate repair service and has an adequate stock of replacement parts.

If you should decide to install the machine, it is absolutely necessary that your engineer set up a routine for cleaning the screens. If this is not done, your utility room will be periodically flooded. Furthermore, obstetrical nurses and attendants should be instructed in the sorting of linen and the loading of the machine. If items such as cotton balls and small sponges are included in the washing, they will plug the mechanism in a short time.

While we have not measured the dollar savings that this procedure has afforded us, the immediate favorable personnel reaction has given much satisfaction and has resolved for us a long-standing problem of the small hospital.

THE MEANING OF GOOD NURSING CARE

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THE interpretation of good nursing care to the patient depends almost entirely upon his physical and psychic condition. If he is dangerously ill, the patient is in no position to determine; if mildly ill or convalescing, he is more likely to judge good or bad nursing *service* instead of nursing *care*.

Just what is meant by nursing service and nursing care? The terms are certainly not synonymous, as has been pointed out by Claire Dennison of the Strong Memorial Hospital School of Nursing, University of Rochester.[1] There can be no clearly defined line between these terms, because nursing service covers much the same ground that nursing care does. However, it goes much farther, embracing many tasks that are not nursing care, such as listing and sending to the cashier charges for laboratory, certain medical and other special services, patients' statistics, the administrative details associated with the admission and discharge of patients, the handling of telephone calls for patients and their visitors.

SECRETARIES THE EXCEPTION

The actual performance or supervision of such tasks as serving meals, arranging flowers, the general neatness and housekeeping of the room constitutes nursing service, which takes hours of nursing time. True, there are a few hospitals with ward secretaries who take some of this load, but they are the exception rather than the rule.

Nursing care has become so complicated and technical, aside from the ordinary hygienic care, that few patients could determine if the service was good, bad or indifferent. Witness the management of Wangensteen suction, tidal irrigation, intravenous injections, intramuscular injections, the care of and knowledge of how to use technical equipment for suction, aspiration, orthopedic and oxygen therapy—all these constitute nursing care,. which few patients are able to recognize qualitatively.

It is pertinent to emphasize the fact that the patient and the general public judge our hospitals and nurses not so much from nursing care as from nursing service. Therefore, all of us, hospital administrators and directors of nursing, should keep this fact clearly in mind.

An important factor in making service stand out more boldly than care to most patients is the change that has come about in hospital practice. Only a few years back, people came to the hospital usually as a last resort. For the most part, they were seriously ill, and neither they nor their families expected anything but expert care. Today a large number of patients comes for observation and diagnosis. This has introduced a new demand in hospital administration. Patients and their relatives now expect hotel service. As a result, many confuse nursing service with hotel service. The business executive admitted for study expects to, and does, carry on his business, not only by room telephone, but also by having conferences with his associates. Because of this, many patients see but little of nursing care, and much of nursing service.

MEDICAL STAFF

To the medical staff good nursing care is to a great extent determined by the kind of duty the staff member expects from the nurse.

The internist is likely to be more concerned with nursing service. With the great advances in biological chemistry, the nurse is expected to assist or even to administer many complicated diagnostic procedures. The collecting of specimens, the proper timing of certain tests, responsibility of getting x-rays, electrocardiograms, basal metabolism, gastric analyses, cystoscopies, all these and others have but little to do with nursing care, for most if not all could be done by any intelligent and instructed person. Interestingly enough, any one of these procedures might immediately become nursing care if the patient were acutely ill, and not just in for observation.

The surgeons are more concerned with nursing care, probably because their patients are usually acutely ill, requiring expert bedside nursing, in addition to the highly skilled technical care that is necessary to handle all the complicated equipment used in modern surgery.

TOO MUCH EDUCATION

Staff members, evaluating nursing care today, are likely to be critical, feeling that there is too much technical education of the nurse at the expense of bedside nursing. Here, indeed, is a curious paradox. With steady pressure, the medical profession has passed over to the nursing profession duties that were considered clearly the responsibility of the physician.

Just one example. Many of us recall vividly enough how during the war, with the shortage of physicians, a few hospitals reluctantly gave in to allowing a graduate nurse to give certain intravenous injections. Today with a more nearly normal quota of house physicians, this duty has not been taken back by the doctors, and it will not be. This example can be multiplied many times. The doctors will continue to hand over to the nursing department new technical procedures, once they are uniform and routine. Probably there should be no quarrel with or resistance to this trend, but how can the staff expect intelligent cooperation and sound judgment by the nurse in accepting these procedures unless she is better educated?

In a survey by Bernays[2] on the "Medical Profession and Nursing," a

From a paper presented at the New England Hospital Assembly, 1948.

[1]Dennison, Claire: Maintaining the Quality of Nursing Service in the Present Crisis. 48th Annual Report, N.L.N.E.

[2]Bernays, E. L.: Medical Profession and Nursing. Am. J. Nursing 45:907 (November) 1945.

suggestion was made by a physician that may be of interest. He asked why medical students or interns cannot be instructed in the relationship between doctors and nurses—what to expect and what not to expect—and given some knowledge of the scope and training of the graduate nurse. As it is, such knowledge is picked up in a haphazard way during internship. This suggestion seems to have merit and might be of real help in promoting better understanding between the two groups.

NURSING STAFF

To the nursing staff good nursing care means more than application of technical skill, for along with it go social and emotional, as well as physical, factors, all of which are concerned with the nursing of patients. The bedside nurse is eager to give efficient care to her patient and carry out her duties to the satisfaction of the doctor. To accomplish this, she must have understanding of purpose and know what are the desired results. Adequate knowledge of procedures is necessary to avoid danger to the patient. Also, procedures used must be approved by the medical staff and the administration. Probably the key to all this is to give the nurse adequate supervision and the time to do her work. If she is too pressed with those duties previously spoken of as nursing service, she will have less time to give nursing care.

One of the outstanding criteria in evaluating nursing care, apart from technical skill, is the ability of the nurse, student or graduate, to inspire confidence in the patient. This requires intelligent use of all the social factors in a given situation. Imagination and resourcefulness are needed. The good nurse makes use of the racial and cultural background of her patient, handling prejudices and superstitions with interest, sympathy, tact and understanding. She must frequently submerge her personal feelings and keep constantly in mind that she is never dealing with normal people, for sick people, as we all know, are far from normal.

Even friends and relatives are hardly normal, making unreasonable demands and criticism. In this connection, the nurse would do well to remember that anyone can get along with pleasant, reasonable people. That's no trick! But the good nurse develops the art of concealing her feeling and remaining pleasant with patients who cannot or will not be pleasant. She must appreciate the fact that patients suffer both physically and mentally.

Good nursing care will not permit reference to the occupant of room 238 as that "difficult" patient, but in the light of modern care, she will try to find out why he is difficult. Refusal or reluctance to eat is not necessarily a childish reaction but may be an outward manifestation that subconsciously the patient doesn't want to get well. To find out or to help find out "why" means good nursing care. Such an attitude not only means good care but wins the deep gratitude of the patient—a reward for the nurse that cannot be measured.

Another item of great importance is the skill and thoughtfulness given to the personal comfort of the sick person. Attention to frequent changing of wet dressings, the bed bath, the alcohol rub for the restless patient are examples of small things that contribute to the comfort of the patient. These are a few of the things that go to make up good nursing care.

The nursing staff evaluates good nursing care by standards additional to those mentioned. To preserve a high level calls, first, for good nurses and then reasonably satisfactory working conditions. Adequate compensation, decent hours of work, good food and lodging, and chances for advancement must all be accepted as fundamentals by the nursing authority, as well as the administration, if good standards are to be maintained.

From the physician, however, comes an unrelenting demand to go even farther in the concept of good nursing care by asking nurses to accept new and complicated diagnostic or therapeutic procedures. Young graduates filled with enthusiasm are aggressive and ready to perform these added duties, but the supervisors and nurse educators know all too well the danger of doing this without more advanced preparation. As a result, nurse educators find themselves in a real dilemma. Their graduates and students are equipped to give good bedside nursing care, but the staff physicians tend to hand over complicated procedures that require more in the way of basic training if intelligent cooperation is to be had.

ADMINISTRATION

Much of the success of hospitals is due to, or dependent upon, the quality of nursing care. Because of this, the hospital administrator must be able to evaluate it. Like the patient and the doctor, he, too, is likely to base his judgment on nursing service rather than care. Are patients admitted properly, their valuables listed carefully, visitors handled with care, the linens distributed with an eye to economical use, food wastes held to a minimum, wards kept neat and clean? Too often, these and similar duties serve as the basis for evaluating good nursing care when they are really nursing service.

To be sure, the busy administrator hears, or recognizes, whether actual bedside care is done well, but too rarely does he know whether those highly technical skills in nursing care are done well. As a result, he also finds himself in the same dilemma as the director of nursing. On the one hand, trustees, staff physicians, and patients are complaining that the nurse no longer nurses, and on the other, the same people are demanding that nurses accept new procedures which seemingly belong in the domain of the doctor.

Many physicians believe hospital schools of nursing have gone too far in the academic fields and are dismayed at any suggestion of increasing these requirements. They believe, as do many patients and their families, that roughly 50 per cent of bedside nursing care can be taught in a few months to a person of average intelligence and as evidence point out the good job done by Red Cross nurse's aides during the war. What they fail to realize is that while the foregoing statement is essentially correct, new and difficult procedures are slowly but constantly being added to the nurse's responsibilities.

One cannot expect cooperation from intelligent people unless they are given knowledge. Therefore, unless doctors stop—and apparently they cannot or possibly should not—assigning these new and complicated procedures, it is, in my opinion, clearly the responsibility of nursing educators to continue their demands for more educational time for students in schools of nursing.

As a hospital administrator viewing the overall problem, it appears that all three, doctors, lay people, and nursing educators, are, to a certain degree, right in each of their respective views and beliefs. What is needed is a clearer understanding of one another and of the problems faced by each group.

Follow-up: IS AN INTEGRAL PART OF SOCIAL SERVICE

OLA GLADYS HYLTON

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SUCCESSFUL follow-up of patients depends upon a great variety of factors, among which are the objectives sought; the adequacy of financing a complete system; the professional relationships and agreements instituted and understood by the physicians in the hospital, by the local physicians, and by the official agencies in the community; the methods and technics used, and the extent of the service given. All of these in turn are dependent upon the professionally equipped persons operating the follow-up system inasmuch as they are responsible for the definition of objectives and the ways and means of accomplishing them within the available resources.

DIFFERENT IMPLICATIONS

Follow-up of a patient with a specific diagnosis implies one thing to the physician but quite another to the patient. The physician in the hospital is primarily concerned with accumulating statistics to aid in the study of the disease and to measure the results of treatment, while the patient is primarily concerned with the disease as it affects him, in determining what can be done about it to cure or to alleviate his symptoms.

To combine the objectives of physician and patient and to assure good results for both require professionally trained personnel to effectuate a system of follow-up, personnel that understands people and how and why they react to given situations, that knows the relationships of physicians, hospitals and communities, as well as the use of definite methods and technics which take all of these factors into consideration. Follow-up, then, may be the significant key to understanding and interpreting the hospital and community relationships which are reflected in professional agreements, agency relationships, and ways and means of exchange of significant information.

A really good follow-up system is of inestimable value to physicians, to the hospital, to the state, and, most important of all, to the individual patient. The true worth of such a system can be measured by the results of service, as well as by the adequacy of the appropriation made by those responsible for the service to operate it efficiently.

Follow-up is not done solely to elicit information but to get and give information for a specific purpose in the total process of the educational service rendered. In other words, information is obtained for use, and during the process of obtaining it the patient needs to know what he can do about his symptoms; he needs to be assured by the people who render the service. His worries and anxieties need to be considered as they relate to his illness, to his family, and to his life in general. While getting and giving information his confidence must be gained and maintained.

Ascertaining the diagnosis, as significant and difficult as the process may be, is of no particular value to the patient unless he can be cured or relieved. The bringing together of the diagnosis, the recommended treatment, and the resources for effective care of the patient is an essential service. Some conditions require treatment over a long period, while others can be treated only in hospitals or in certain places with particular kinds of equipment and by physicians especially qualified to give the treatment. To make this information available to the patient and his family, and to others if necessary, and to see that he gets the essentials recommended require many consultations and interpretations through all of the known methods of communication.

The existence of a cancer clinic or diagnostic unit does not help the individual if the clinic or unit is not accessible to him. Recommendations made by such diagnostic facilities are valueless to him if they cannot be carried out. In June 1933 the board of regents of the University of Michigan authorized the medical school and the University Hospital to establish a cancer clinic in the hospital and approved a committee to carry on the work. Authorization was given by the regents on recognition of the fact that the work would not involve any additional expense but was merely a grouping of men and facilities already available. (1) The active operation of the clinic so authorized did not begin until February 1936 at which time the social service department was asked to assume responsibility for the follow-up of all cancer cases. (2)

Follow-up is an essential and integral part of the educational and research service done by social service and has been carried on for more than twenty-five years with thousands of patients in many diagnostic categories, but it was necessary to set up a permanent and cumulative file to follow such a large group year after year as was desired by the cancer clinic. (3)

Follow-up for the cancer clinic which started out as a fairly simple assignment of 200 cancer cases in 1936 has now grown by leaps and bounds to the astounding figure of 40,000. Each month two or three hundred new names are added to the list.

ONE-TENTH SENT TO CLINIC

Actually, only about one-tenth of all cancer cases diagnosed in the hospital are seen in the cancer clinic which now refers to itself as the neoplasm conference. Only those patients who present interesting neoplasms and difficulties in diagnosis and about whom there are questions regarding treatment are presented before the conference. (4) However, it is necessary to follow all persons who have a diagnosis of cancer.

Many systems of follow-up have been tried in different places by numerous individuals with varying results. Naturally, the most effective system is one designed to meet local conditions which will produce the highest degree of efficiency with the minimum cost. Inasmuch as most of the patients at the University Hospital do not come from

the immediate vicinity but from the state as a whole, and adjoining states under some circumstances, and move with surprising rapidity over the entire globe, correspondence has proved to be one of the most effective tools. This affords a written and permanent record of progress. Obviously, this means keeping a complete and separate cancer file, dictating, replying to, and redirecting thousands of letters each year—letters not only to patients and their relatives but also to their referring doctors, to official agencies, and to other acceptable sources in order to obtain, interpret and exchange essential data.

DON'T KNOW THEY HAVE CANCER

About 65 per cent of the patients followed do not know they have cancer which adds materially to the difficulty. Neither medical nor social information about a patient is released without his written consent, which assures him that his confidence will be maintained at all times under all circumstances. There is no routine follow-up. It is not a process of circularization of a questionnaire and addressing an envelope but is a specialized service-giving procedure. The service is individual in character, considering the particular problem, the needs and the idiosyncrasies of each patient and his relatives, the referring doctors and others insofar as it is possible.

In order to provide this service, it is imperative to have smooth functioning of what is frequently referred to as the mechanical factors. It is necessary to have file clerks and stenographers because it is essential to have a complete file, to have thousands of letters transcribed, to have information from letters typed on a special neoplasm-study form, to have the form attached to the medical record, and to requisition thousands of medical records from the central record room, among other things.

The follow-up system reflects itself in many vital spots in the hospital. On the patient's first or returning visit, the registration office obtains identifying information. At this office it should be feasible to obtain for all patients the names of at least two relatives, and their complete addresses, so that it would be possible to locate them at any time through one or the other. Bed reservations are made at the admitting office for returning patients. The credit office has to decide about costs for returning to the clinics. The record room has to handle thousands of records and see that case summaries are sent to referring physicians at the patient's request. The pharmacy has to fill prescriptions. Not only these units of the hospital but also many others are involved in service to patients. Endless difficulties have to be surmounted before the return of the patient is effectuated.

If follow-up were merely a mechanical procedure whereby a form could be sent and an answer automatically received which closed the case, it would be simple. But follow-up as a service-giving and educating process is much more complicated. If the patient is well, the objective is to have him remain so. If he has symptoms, then it is necessary to have them evaluated and to ensure for him the most effective treatment for his particular condition.

Through follow-up, he relies upon adequate medical care and knows that new developments in treatment may be made available to him. Effective follow-up must consider all needs of the patient, regardless of their nature.

Every effort is bent to keep the individual under observation by his referring physician, and in order to do this letters must be written to physicians, and case summaries must be sent. Interpretations must be given to relatives and agencies that assist patients in making arrangements for return, or for providing care in the local community. Conveyors from different counties of the state who bring patients to and from the hospital must be consulted for arrangements to return a patient on a given date. Then, of course, patients must be counseled about other problems that confront them.

Eager, impatient to get home, the patient does not at the time of his discharge from the hospital absorb much of what is told to him regarding diagnosis, treatment and return. Furthermore, until he reaches home and begins to adjust himself once more, he does not know what his problem will be. He is scarcely prepared for the reality of it. He has a complex adjustment to make to his condition, his family, and his community. He may not know his diagnosis, and his newly awakened fear may cause greater anxiety than the knowledge of the diagnosis. Follow-up, then, provides him with the opportunity for expression of his many problems. (5)

SPECIAL GROUPS CHECKED

In addition to the regular neoplasm follow-up, physicians in the hospital request follow-up on special groups of patients with neoplasm at certain times. They make special requests for follow-up not only of certain neoplasms but of other diagnoses also. These have included various categories, both medical and surgical. (6)

Every attempt is made to obtain accurate and reliable data; however, no guarantee of authenticity is made beyond giving the source. The reason is obvious. Physicians in the local community may give information that the patient is dead; yet he may be alive and may walk into the clinic after such a report has been given. Relatives sometimes give erroneous dates of death.

The cause of death is a serious concern to the statistician who is never wholly satisfied with the cause of death as given by the attending physician. The county clerk who records the certificate of death is responsible only for filing the record. The physician may give only the most obvious cause or merely designate "heart failure" with no reference whatever to the neoplasm. Recording of deaths and their causes may be vague, indefinite and inaccurate. Death information is obtained from the county clerk in each county when it is available. But the spelling of the

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name, the original name and the changes which have taken place in spelling, and the place of residence all add to the complicating task of tracing the patient.

Accuracy of data received is not guaranteed any more than are 100 per cent results of responses from follow-up. The latter is dependent upon many factors. If the individual is not referred to us for several years after his hospital care, it is indeed difficult to trace him, and to get him to respond to communications and take any interest in the purpose of follow-up. But when the person has been referred soon after his diagnosis is made, it is possible to say with relative certainty that with adequate personnel, the results could approximate the 100 per cent goal.

Michigan's interest in cancer prior to 1905 was only incidental. But in 1905 cancer was included among the reportable diseases, and in 1909 the state board of health published its first pamphlet on prevention and control of cancer. (7) In recent years, efforts have been made by the Michigan State Medical Society, the Michigan Department of Health, and others to bring to the professional and lay groups an effective educational program for the control of cancer. The principal objectives of their program are to educate the medical profession and the public regarding the nature, causes, treatment and prevention of cancer, and to increase and improve the facilities for its diagnosis and treatment. (8)

In spite of these efforts a great many patients do not reach the hospital until their disease is well advanced, too late for treatment which might have been effective in the early stages. There should be an expansion of the educational program for both professional and lay groups, and it should be supplemented by the absolute assurance to every patient that he would be able to obtain early and continued care and treatment as recommended by the diagnostic unit.

No effort should be spared for general education which will encourage people to see their physicians early or for increased technical knowledge for physicians which will enable them to make a diagnosis early and to treat the case properly. And, certainly, no effort should be spared for education of the individual who has the disease—education that will aid him in understanding the problem which is of paramount importance to him and his family.

WHOSE BABY?

This Method of Identification Is Simple and Sure

RITZ E. HEERMAN

Superintendent, California Hospital, Los Angeles

DURING the last ten years, I have considered the many problems that arise concerning the identification of the newborn. My interest was stimulated by a law suit against the California Hospital, Los Angeles, for an alleged mix-up of babies. Many hospitals have been in the limelight of the public press owing to similar circumstances. It is obvious that there are few, if any, actual mix-ups of babies in which the wrong baby is sent home with the mother, for most of the alleged cases are based on suspicions and the fact that hospitals do not have a uniform and foolproof identification system. A standard system would obviate much of the difficulty now encountered.

It must be admitted that a variety of systems has been designed by hospital administrators, nurses or doctors. They include strings with metal tags, beads, wrist and ankle bands sewed and clamped, adhesive tape, ultra-violet radiation, and many others with minor deviations to suit the individual whims.

What are the essential requirements of an effective system?

1. There should be more than one marking for identification.

2. The mark should be easy to apply but certain to remain on the infant.

3. It should be correlated with something that can be identified with the mother, such as finger prints.

Recently, a Los Angeles manufacturer has become interested in producing a baby identification system that I believe overcomes the weak points of all other systems used.

The main feature of this system is plastic impregnated linen used as follows:

1. Three of these plastic impregnated bands properly marked with the baby's name and the mother's finger print are used. One is placed on each wrist and one on the ankle. The bands are flexible, and none of the materials will harm the baby's skin.

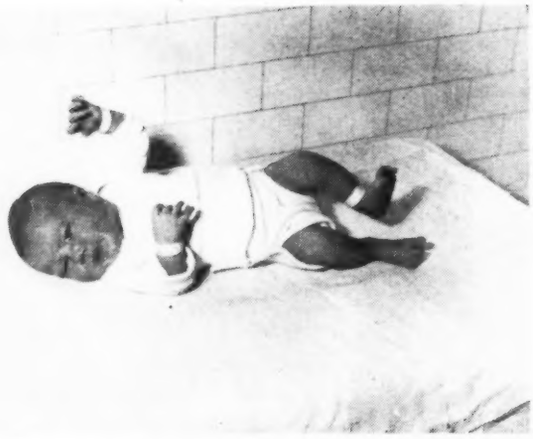
2. Special plastic seal, in liquid form, is used to seal the bands around the wrists and ankle, and because the seal material has an affinity for the plastic materials already in the band, a permanent joint is obtained without using staples or stitching.

3. The seal material is also placed over the markings and the mother's finger print, thus making the whole band impervious to water, oil, soap, solvents or any other solutions used in the hospital.

The identification materials needed in the delivery room include three sterilized plastic impregnated bands, special seal, rubber stamp set and pad, finger print set, pen and ink.

Before the mother or baby leaves the delivery room, the following procedures are carried out.

Section of delivery room, showing newborn baby in warmer, and nurse preparing identification material.



Bands, marked with the baby's name and her mother's finger prints, are attached to wrist and ankle.

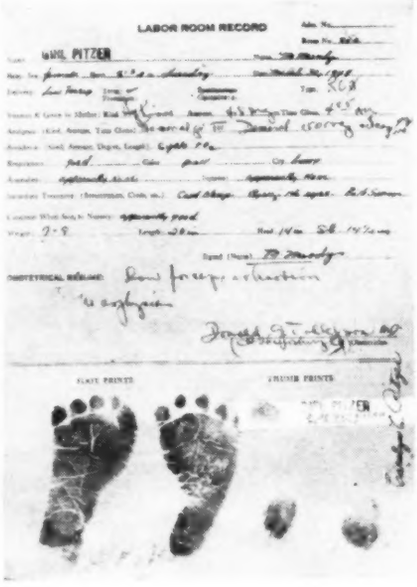
1. The nurse who is responsible for the identification sets up a rubber stamp with letters at least 3/16 of an inch in size. This rubber stamp is set up with the mother's last name and if it is a common name, the mother's initial, prefixed by the word "boy" or "girl" as the case may be. After the rubber stamp has been set up, it is proofread against the mother's chart. If it is correct, this stamp is then used to imprint the mother's chart, the back of the souvenir birth certificate, the back of the public birth certificate, the heading of the baby's chart, crib card, and all other auxiliary papers used in the hospital. The three bands are then imprinted with the stamp. Underneath the imprint, in pen, are written the date, exact time of birth, the doctor's name. The mother's index finger print is also placed on each band, as well as on the hospital's records.

SEALED WITH PLASTIC

2. Plastic seal supplied in a tin-foil squeeze container is applied over the markings including the finger print. The two ends of the band are also coated with the seal, and then one band is placed on each wrist and one ankle. By holding the ends containing the seal together between two fingers for a few seconds, the band is made secure.

3. This gives an absolute marking system, and the mother's finger print on the band will be an indisputable identification. However, it is important that the mother is informed in writing or by means of a circular about the identification system used. If foot prints are taken, the mother should be informed that these are merely for souvenir purposes and they can seldom be used for identification. The circular should also emphasize that it is the mother's responsibility as much as the nurse's to check each time the baby is brought to her and that she, with the nurse, must check one of the arm or ankle bands. *This is an important part of the identification system.*

Most alleged mix-ups stem from the fact that it is easy for the nurse to bring the wrong baby to the mother. This occurs frequently in every hospital. When the mother is not informed that she has some responsibility in the identification each time the baby is brought to her, the hospital assumes the entire burden. If a mother receives the wrong baby once or twice, she may gain impressions of the baby's appearance and if the right baby is given to her the next time, she will immediately be apprehensive and probably construe that it is not her child.



Part of the infant's chart with band glued to it and mother's signature across the band.

4. When the mother and baby are to be discharged from the hospital another precautionary step must be taken. One of the bands is cut and removed in front of the mother. It is compared with the other two bands remaining on the baby. It is also compared with the mother's and baby's charts. The band is then fastened to the child's chart with some of the plastic seal. The mother signs her name to that part of the chart with her signature overlapping the band. The mother is then told that she can remove the other bands when she gets the baby home and place them in the baby's souvenir booklet. A quantity of seal can be given or sold to her for this purpose because ordinary glues will not adhere to the plastic band.

SYSTEM ELIMINATES ERRORS

If every hospital used a standard identification procedure, I believe there could not be any suspicion or charges about mix-ups of babies. Such a system would establish confidence and good public relations for hospitals. Here we have the possibility of a good standard system, inexpensive and requiring the least amount of time of hospital personnel. This system can also be used for identification of children in the children's department and will thus eliminate any possibilities for errors in treatment.

Rendering of the Alfred E. Smith Memorial, St. Vincent's Hospital. The tallest, dominant building is planned to front on Seventh Avenue. First step in the project is the ten-story structure shown on the rendering on Twelfth Street adjacent to the larger building at the corner. The rendering presents all steps of complete project.

Business Goes on as Usual During Alterations at St. Vincent's

EDWARD W. THODE
Eggers and Higgins, Architects, New York City

ST. VINCENT'S HOSPITAL in New York City is launched on the first steps in a major construction project involving erection of the new ten-story, $4,000,000 Alfred E. Smith Memorial and simultaneous renovation of an existent seven-story structure housing 323 of the hospital's 541 beds, at an approximate cost of $1,000,000.

Because major structural changes are required while the hospital continues to function, this project reaches into every nook and cranny of the institution, affecting every department and calling for a degree of synchronization that is, perhaps, the eternal challenge to all hospital administration.

For a hint of the series of administrative reverberations spreading out from the project, one need look no farther than the first item on a long list describing preparatory work required prior to demolition of the building to be replaced by the Alfred E. Smith Memorial.

The first item on the list reads:

"Tunnel through east wing of Twelfth Street building (semiprivate pavilion) to provide access to court."

Construction of a new kitchen and laundry at basement and subbasement levels in the court in the rear of the building, and the demolition of court buildings, left no alternative but to get in there first. Trucks could get in and out only through a tunnel. And so the administrative ripples in the pool began.

In rapid succession, the series of preparatory steps unfolded. These included: installation of electric refrigerators for all buildings to assure uniform and continuous operation during construction, when the present brine system is removed; establishment of temporary storage spaces, new electric service lines, and hot water tanks; creation of temporary nurses' stations, reconditioning of an incinerator; establishment of a temporary butcher shop, salad room, and relocation of concomitant refrigerators; a new bridge from one building to another; demolition of court buildings—and many other items.

Obviously, not even the preliminary structural steps could be devised without consultation with the hospital administration. Thus, from the beginning, the entire program of work had to be closely linked with practical day-to-day problems of hospital functioning.

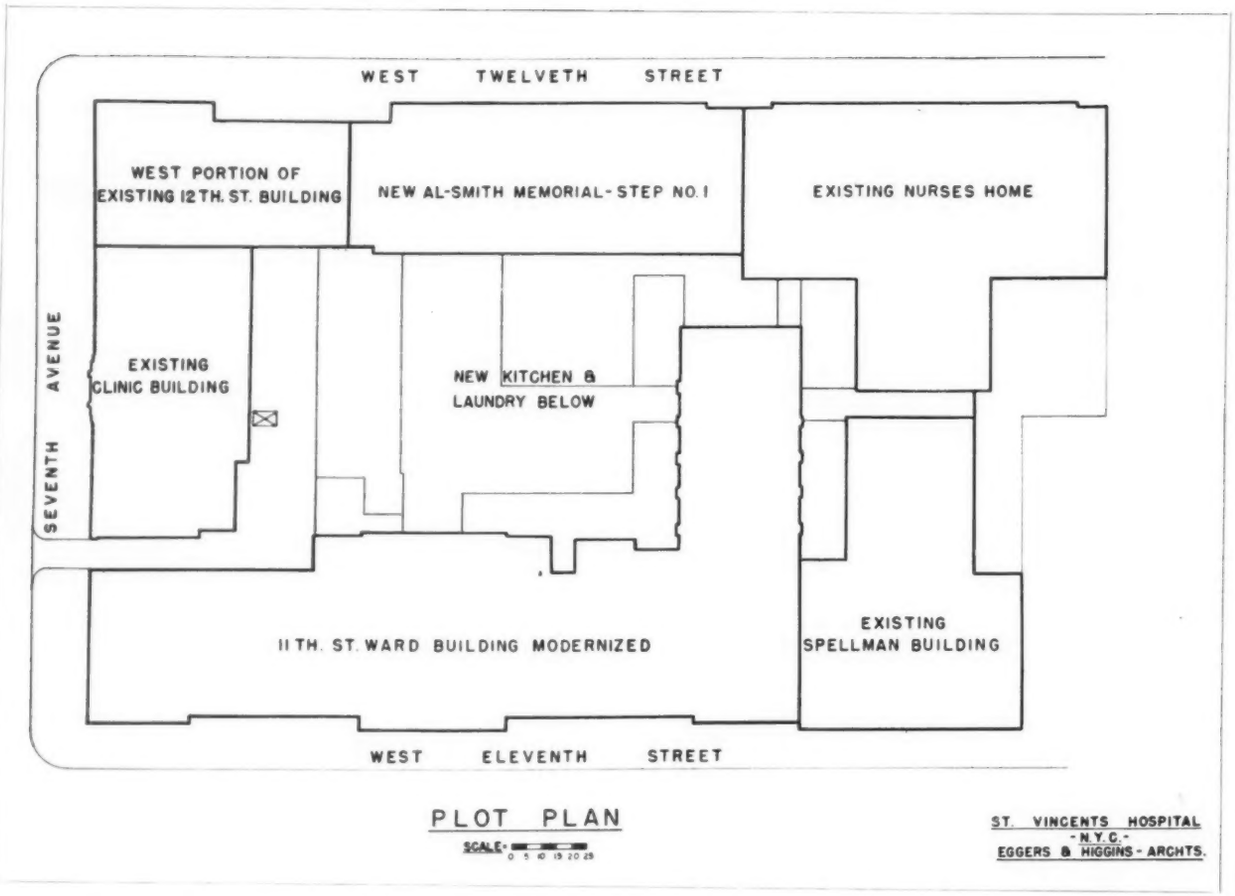
It was necessary to determine not only upon an immediate construction plan, but also upon the meaning of the plan in terms of final expansion. The problem was, in effect, the imposition of a sort of master plan on an existent institution confronted with all the customary restrictions of a long established, going concern. Thus, an all-encompassing program was envisioned at a total cost of perhaps $12,000,000. From this was extracted the construction of "Step 1," the Alfred E. Smith Memorial and the renovation of the Eleventh Street building, aggregating approximately $5,000,000.

The Alfred E. Smith Memorial, now under construction, will be a ten-story building and penthouse, with cellar and subcellar extending under the present interior court.

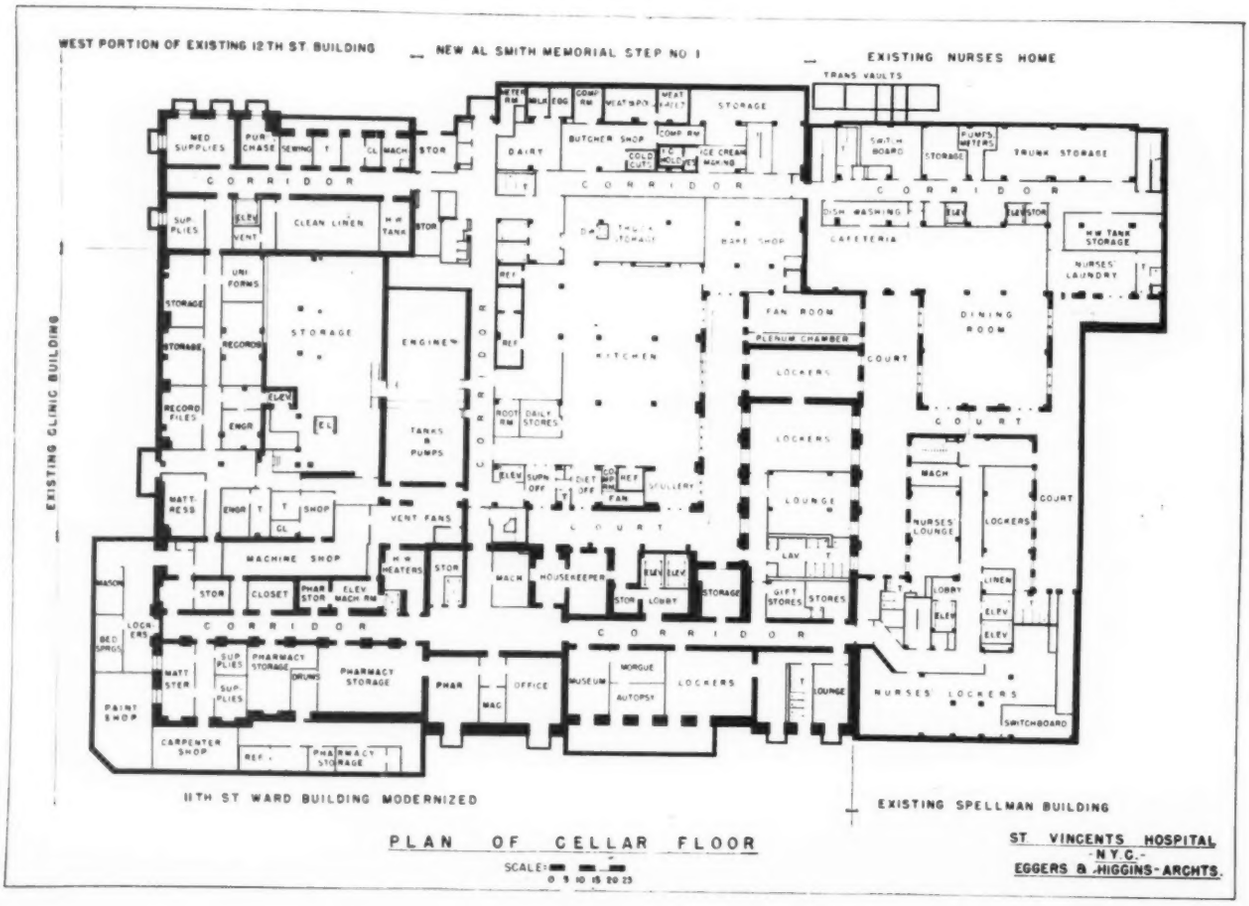
Here is a glimpse of its facilities:

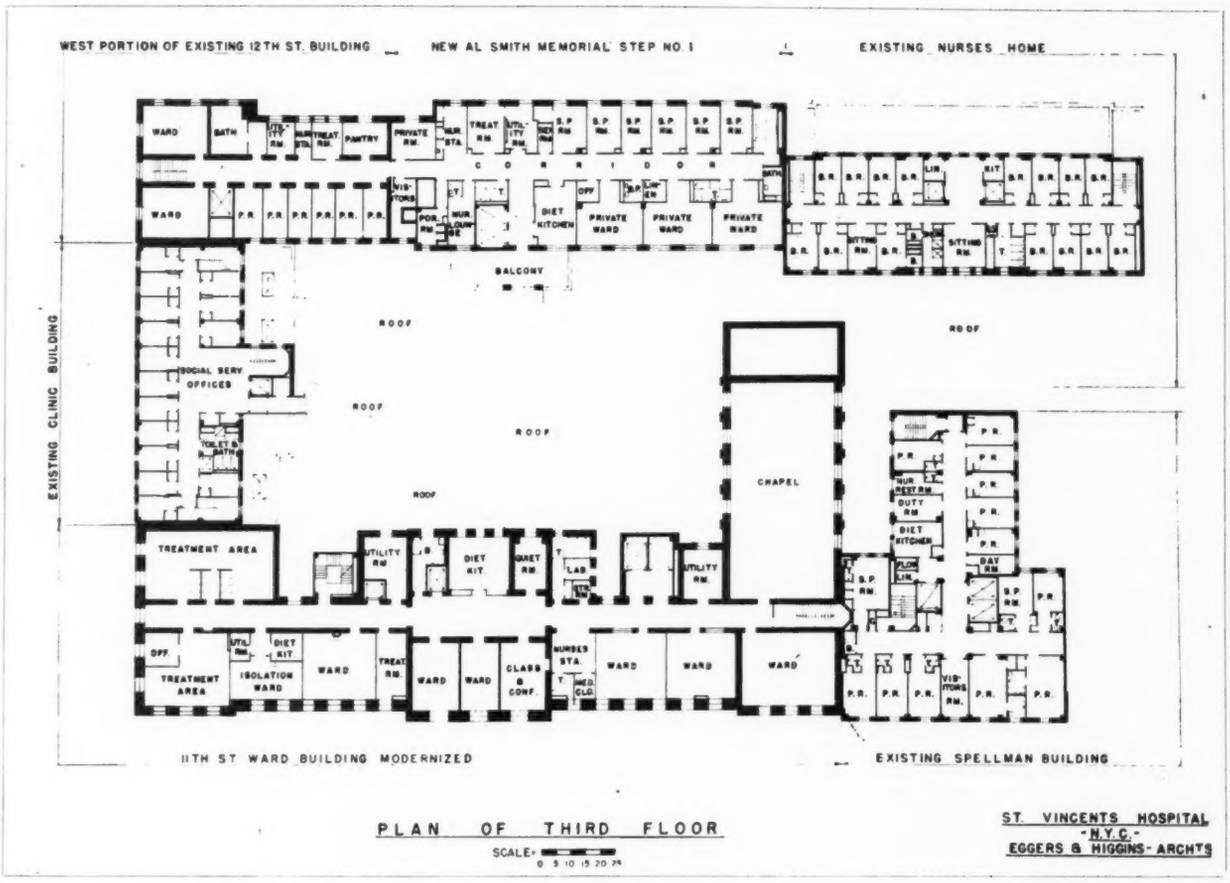
Subcellar: Laundry, linen storage,

(*Continued on Page* 72.)



PLOT PLAN AND TYPICAL FLOOR PLANS:



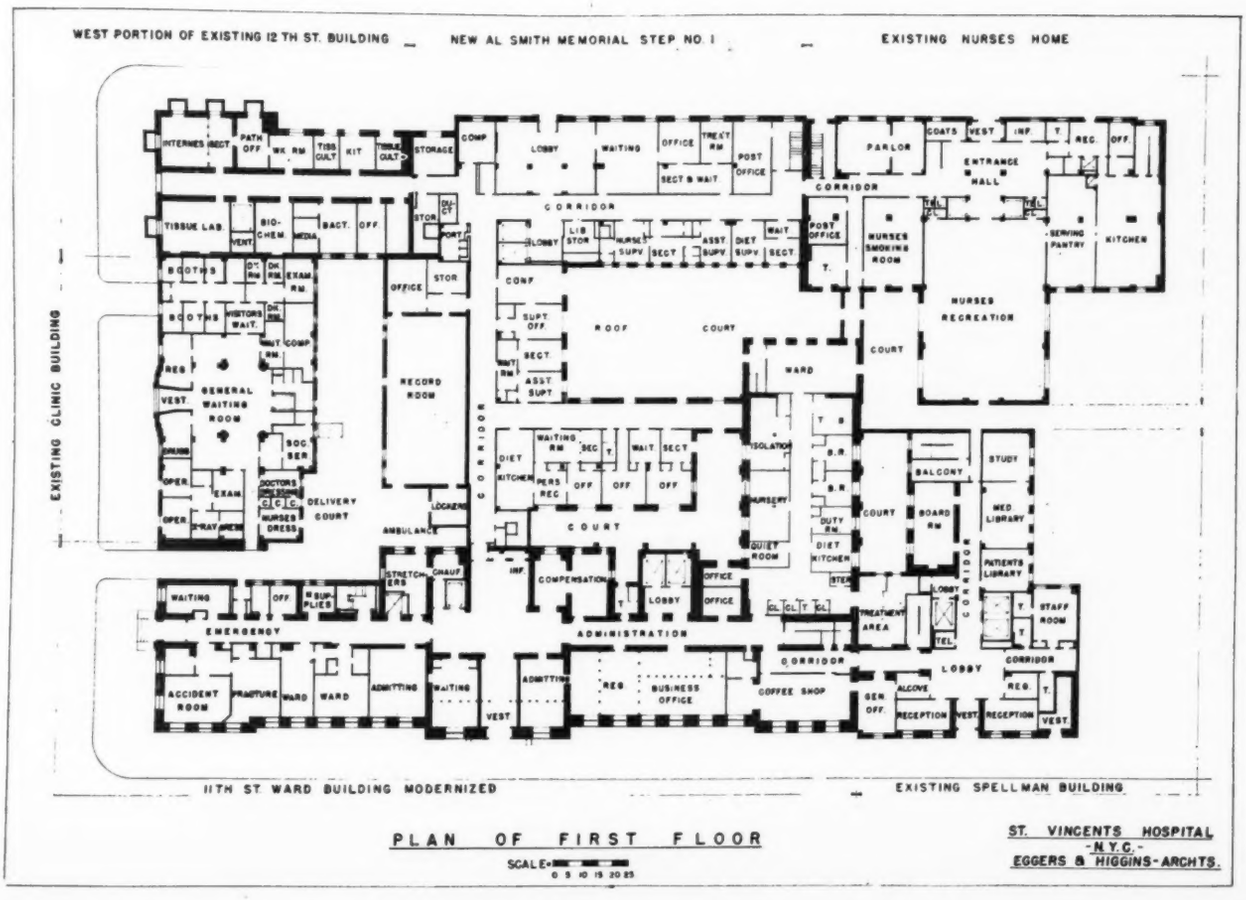


PLAN OF THIRD FLOOR

SCALE: 0 5 10 15 20 25

ST. VINCENTS HOSPITAL
-N.Y.C.-
EGGERS & HIGGINS-ARCHTS

ALFRED E. SMITH MEMORIAL BUILDING



PLAN OF FIRST FLOOR

SCALE: 0 5 10 15 20 25

ST. VINCENTS HOSPITAL
-N.Y.C.-
EGGERS & HIGGINS-ARCHTS.

machine room, tank and ejector pit room.

Cellar: Main kitchen, truck storage, bake shop, scullery, offices, salad preparation and temporary butcher shop, refrigerators and kitchen storage.

First floor: Administration offices and temporary main entrance, lobby and waiting room, staff conference room.

Second floor: Nurses' and staff dining room.

Third to tenth floors, inclusive: Private, semiprivate and ward rooms, with open-air balconies.

This new building, in regard either to construction or to administration, could not be separated as a project from the renovation of the old seven-story building on Eleventh Street which houses the wards. In the planning the two had to be interwoven in administrative terms.

In general, the Eleventh Street renovation aims at modernization. Incidentally, it provides new useful space. One space saver is elimination of two old space consuming stairways and the substitution of one new firesafe stairway.

Grouping together the expansions resulting from both projects, we therefore have the following:

In the Alfred E. Smith Memorial building, Step 1: Expanded laundry and laundry storage, kitchen and auxiliary services, administrative offices and dining rooms.

These expansions will free space in the present nurses' home so that the result will be new recreation space, new dietetic classroom, and new dining room for employes.

The renovation of the Eleventh Street building will provide expanded administrative offices and x-ray facilities, new physical therapy, new isolation wards for adults, and new and expanded lockers, lounge and toilet facilities for nurses and employes.

The renovation will, in addition, result in modernization of all wards and services, including the maternity department with its nurseries and formula room, and will make the whole structure fire resistant.

This step of the St. Vincent's program does not contemplate an overall increase in the total number of beds, but rather a rearrangement of categories and an elimination of the overcrowding of wards which will result in a small but not significant increase in capacity.

Steps in the renovation process, planned to avoid interference with operation of the wards now housing 323 beds, are of more than passing interest.

It was determined first to construct the new stairway. When this has been completed, the space occupied on every floor by the old main stairway will be free. It will then be used for relocation of kitchen services currently housed in more than one location on each floor. This space, in turn, freed by removal of kitchens to the larger spaces, will be renovated for use as utility rooms, and the space now serving as utilities will then be converted to other uses, and at the same time the toilets and baths will be modernized.

This "checker-game" technic is planned as we progress toward final, complete modernization of the building. Only in one case will there be what might be described as cessation of an activity and that is in the wards when the renovation will require new partitions and lighting, and one ward at a time will be closed to permit the change. No amount of theoretical transposition of space could avoid that. However, the curtailment of service, in terms of the whole, is obviously negligible.

Among the many perplexing problems that confronted the administration of the hospital was the determination of the size of service facilities. Obviously, it would be imprudent to build new service facilities, only to find them inadequate in the light of the ultimate "master plan." The decision finally reached was that these auxiliary service facilities, such as kitchens and laundry, should be adequate, now, to meet the demands of future expansion. While this limited the number of expanded facilities, it assured orderly growth and minimum readjustments in the future.

Alternative to Microfilming

RICHARD T. VIGUERS
Administrator
Joseph H. Pratt Diagnostic Hospital, Boston

DICTATING machines that make use of a plastic disk in place of the conventional wax cylinder are now on the market. Inasmuch as this plastic disk is practically indestructible, a system might be worked out whereby it could be retained as the permanent clinical record when storage space limitations required the destruction of old typewritten records. Instead of microfilming these records one would merely destroy the typewritten sheets and retain the plastic disk.

The system could be worked along these lines: When a patient is admitted to the hospital, the plastic disk would be started by dictating onto it the social data obtained in the admitting office. This disk would be inserted in an envelope and go along with the patient's record.

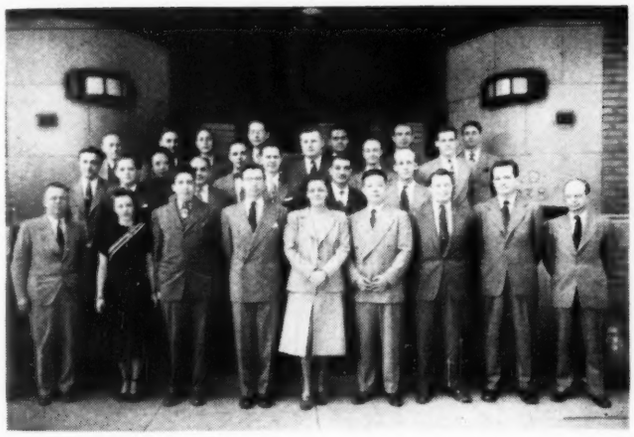
The patient's history, physical examination, and other preliminary data would be dictated onto the same plastic disk. The second record could be started for the operative notes, progress notes, consultations and final data at the time of the patient's discharge.

This system would give a permanent record that would take about one one-hundredth of the space of the typewritten record and would save on the expense of microfilming as well as the cost of the reading equipment, which, in our hospital, would be about $3000 a year. Up to twelve or fourteen typewritten pages can be recorded on the plastic disk which is 6 inches in diameter and slightly thicker than a heavy piece of paper.

When it is desired to consult an old record, the disk would merely be put onto a dictating machine and played back through the speaker. If necessary, the record could always be retyped. Since each part of the dictation could be started with the name of the speaker, *e.g.* "This is Dr. Carl Jones," the information in the record could be as easily authenticated as could the signature of Dr. Jones on the written record.

Although there are limitations to such a system, it would provide a permanent record requiring minimal storage space at practically no additional cost of time or equipment.

PEOPLE IN PICTURES—GRADUATION DAY



COLUMBIA UNIVERSITY: First row, l. to r.: Dr. John Gorrell, Mary E. Patterson, Dr. Luis Oliva, Bohn Lindemann, Dr. Vendela Olson, Dr. Hsi-Ming Chang, Alfred Van Horn, James Jenkins, James McLaughlin. Second row: Anthony De Luca, Anthony Esposito, Roy Stephenson, Dr. Bertram Marks, Thurston Long. Third row: Herbert Gillis, Szetu Dju, Dr. Albert Dreisbach, Sherwood Messner, Robert Wallace, John Galloway. Top row: Dr. Carman Kirk, Francis Petrie, William Woods, Dr. Ellsworth Neumann, Dr. F. Lloyd Mussells, William Kozma and Gilbert Moss.

NORTHWESTERN UNIVERSITY: First row, l. to r.: Josue Pagan-Carlo, Eileen G. Damiani, John E. Paplow, Blanca de Garcia, Dr. Pedro A. Garcia, Alfrieda Z. Cockrell, Alice E. Harrison, Norman L. Thompson. Second row: Charles A. Turner Jr., Anthony C. Guzik, Carl T. Heinze, Joseph M. Henry, Carl D. Rinker, Cleveland R. Chambliss, W. Obed Poling, H. Ernest Bennett, Alfred Henry, Joseph S. Hew, Harry C. Bach, John William Edler. Back row: J. B. Schroeder, Kenneth L. Winters, Sterling E. Gill, Robert V. Fay, John W. Shy, Stephens A. Lott, Robert E. Henwood, Herbert R. Roddee, Roy C. House, Anthony S. Dickens, James R. Gersonde.

YALE UNIVERSITY: Front row, l. to r.: Nelson F. Evans, Dr. Hilda H. Kroeger, Dr. Albert W. Snoke, professor of hospital administration; Henry B. Kidder, Dr. Joseph H. Gerber. Second row: Edmund R. Mattos, Ernest M. Sable, George W. Brooks, Dr. Clement C. Clay, director of course in hospital administration, and Edgar L. Geibel.

UNIVERSITY OF MINNESOTA: Front row, l. to r.: Telmer O. Peterson, Aileen Foley, James W. Stephan, associate professor of the course; James A. Hamilton, director; Ray M. Amberg, superintendent, University Hospital; Richard L. Kozelka, dean, School of Business Administration. Second row: Herbert A. Anderson, Frederick S. Burd, Donald Freeman, David Olsson, Theodor Jacobsen, Kenneth Wolz, Russell Williams, Leroy McKenney. Third row: Stephen B. Fuller, Bruce Root, William Weeks, William Schueller, Jerome Bieter, George Stone, Earl Dresser, Rodney Hemsworth, Robert Griffiths.

SMALL HOSPITAL FORUM

ADMINISTRATORS' SALARIES

They'll Never Get Rich—but They Like Their Jobs

HIS sex is worth exactly $1740 a year to the male hospital administrator, a salary survey covering a group of small hospitals reveals. The group consisted of forty-two hospitals averaging seventy-nine beds each; the average administrator's salary is $4713, plus minor maintenance perquisites. Twenty-three of the administrators reporting are men, with salaries averaging $5500. The other nineteen are women, and their salaries average $3760.

That the difference of $1740 is based on sex rather than size of hospital or any other factor is apparent from the fact that the men administrators in this group are in hospitals only slightly larger than those run by women. Average bed size of the men's hospitals is eighty-one, while the women's hospitals have seventy-six beds on the average.

LARGER POPULATION: HIGHER SALARY

For study purposes, the table summarizing the results of the survey shows the population of the area served by each hospital and the location by region of the country. While correlation is not complete, the tendency for higher salaries to be paid in the larger population centers emerges clearly. In this group, somewhat higher salaries are noted in New England ($5220 average), the Middle Atlantic States ($5240), and the Southwest ($5029), compared to the Middle West ($4564), the Southeast ($4595), the Pacific Coast ($4590), and the Mountain States ($3710). Plainly, however, the groups are not large enough for these regional differences to have any significance.

More interesting is the division of salaries according to size of hospital. Here a definite pattern is discernible: The larger the hospital the larger the salary. Hospitals with 100 or more beds report salaries averaging $5809 a year; in the fifty to ninety-nine-bed group, administrators' salaries average $4349, and in hospitals with forty-nine beds or less administrators get an average of $3493.

In sixteen of the reporting hospitals, the cash salary is the only reimbursement the administrator gets. In the others, some additional perquisites are noted, ranging from a single meal a day to full room, board and laundry in a few cases. Study of the accompanying table will show that in most of the cases where full maintenance is provided, the administrator is a woman with a comparatively low cash salary.

The average salary in the group has increased 8 per cent in the last year, from $4362 to $4713. Over a three-year period, the salary has increased 19 per cent. In 1945, these administrators were earning an average salary of $3950. Whether or not these increases have kept pace with the cost of living in the hospital communities is a matter for debate. Asked if they think their compensation has kept abreast of increased living costs, twenty-seven administrators, or nearly 65 per cent of the group, say "No." Twelve administrators are satisfied with their increases, and the remaining two did not answer.

A somewhat larger number of administrators believes administrative salaries are inadequate in consideration of the responsibilities carried by the administrator. Asked this specific question, thirty-two administrators say their salaries are inadequate, and only nine feel they are paid as much as they deserve. "I would like to feel that my salary is adequate," one woman replies, "but it probably is not, considering the fact that the superintendent of a small hospital is on call all the time." Another adds that her salary is also inadequate compared to that paid to other personnel in the hospital. "I am on call twenty-four hours a day and am required to live in," she notes, pointing out that other hospital workers now have short, regular working hours.

CONTRAST WITH COMPARABLE JOBS

Several administrators underline the difference between their salaries and those paid for comparable jobs in business and industry in their communities. One man who gets $3500 a year for running an eighty-five-bed hospital states his opinion that comparable responsibilities in industry in his community would bring "a minimum salary of $7500." With some bitterness, another man declares, "You can make more cash money driving a truck on a government project in this community." His salary is $3600, plus house and utilities, for a seventy-seven-bed hospital.

Among those who report satisfaction with their pay is one frank soul who says, "I am overpaid for such a small hospital." This man is at one of the smaller hospitals in the group and is paid $5400 a year.

About the same division of opinion exists on the question, "Is your compensation adequate to support the position in the community you feel you should have?" Twenty-seven administrators say that it is adequate, and fifteen say that it is not. In the latter group, however, are several men who noted the fact that they are not married. "My present salary is enough," one of these men states, "but it would not be enough if I had a wife and

SALARIES OF SMALL HOSPITAL ADMINISTRATORS

Region	Area Population	Beds	Sex	Present Salary	Salary 1 Yr. Ago	Salary 3 Yrs. Ago	Perquisites	Is Salary Adequate: For Increased Living Costs?	For Responsibilities?	For Position in Community?	Would You Leave Hospital Field?	Motivating Factors*
New England.....	20,000	140	M	$ 8,400	$ 6,000	$ 5,000	Meals	Yes	Yes	No	No	S E P Q
	2,700	47	M	3,000	.....	.....	No	No	No	No	No	S Q J
	1,000,000	150	M	10,000	8,500	.....	Pension	Yes	Yes	Yes	No	S Q E
	50,000	91	F	5,360	5,360	5,360	R. and L.	....	Yes	Yes	No	Q S
	3,500	50	F	3,300	3,300	2,820	Maintenance	No	No	Yes	No	S Q P E
	6,000	35	F	2,700	2,700	1,920	Maintenance	Yes	No	No	No	S E Q P
	25,000	50	M	3,600	3,000	.....	Maintenance	No	No	No	Yes	S Q E P
	50,000	20	M	5,400	4,800	.....	No	Yes	Yes	No	No	S P Q
Mid Atlantic.....	45,000	102	M	7,200	6,000	6,000	Meals	No	No	Yes	No	S Q E P
	3,000	125	F	4,200	3,600	2,760	Maintenance	No	No	No	Yes	S
	1,500	100	F	5,500	5,500	3,600	Maintenance	Yes	No	Yes	No	S Q P E
	2,000,000	100	M	6,000	5,000	.....	Home	No	No	No	No	S E Q
	45,000	82	F	3,300	3,300	3,000	One Meal	No	No	Yes	No	Q E S P
Mid West.....	30,000	103	M	6,500	6,500	6,500	No	No	No	No	Yes	S Q E P
	25,000	100	M	5,500	3,900	3,000	Meals	Yes	Yes	Yes	No	S J E Q
	30,000	95	F	4,200	3,600	3,300	Maintenance	Yes	Yes	Yes	No	S E Q P
	14,000	45	F	3,480	3,000	2,400	Maintenance	No	No	No	No	S Q P E
	16,000	85	M	3,500	.....	.....	No	No	No	No	No	S P Q E
	11,000	105	F	5,100	4,500	4,500	Maintenance	No	No	Yes	No	Q S P E
	25,000	87	M	6,000	6,000	.....	No	No	No	No	No	S E Q P
	9,000	107	F	3,600	3,000	2,700	No	No	No	No	No	S E Q P
	6,000	36	F	3,300	2,700	2,400	Maintenance	Yes	Yes	Yes	No	S P Q E
Southeast.....	12,000	67	F	3,300	3,300	.....	Maintenance	No	No	Yes	No	S Q E P
	27,000	85	M	5,000	5,000	4,600	No	No	No	No	Yes	S
	350	74	F	3,000	3,000	.....	Maintenance	No	No	Yes	No	P Q S E
	125,000	102	F	3,060	2,925	2,400	One Meal	No	No	No	Yes	S E Q P
	18,000	100	M	7,500	7,500	7,500	No	No	No	No	?	S Q P E
	250,000	50	F	3,000	.....	.....	Maintenance	No	No	No	No	S Q P E
	18,000	55	M	6,500	6,500	6,500	Medical Prac.	....	....	Yes	No	S Q
	14,000	75	M	5,400	4,800	4,800	No	No	No	No	No	E Q S P
Southwest.....	20,000	60	M	3,600	2,880	.....	No	Yes	No	No	No	P E Q S
	22,000	55	M	7,550	6,400	6,400	Meals	Yes	Yes	Yes	?	S E P Q
	21,000	50	M	6,000	5,400	3,900	No	No	No	No	No	S E Q P
	15,000	75	F	2,964	2,964	.....	No	No	No	No	....	S
Mountain.....	10,000	62	M	3,600	3,000	2,750	No	No	No	No	....	E P S Q
	17,500	77	M	3,600	3,000	.....	Home	No	No	No	No	S Q P E
	1,800	23	F	3,080	3,000	2,700	No	Yes	Yes	Yes	No	S Q P E
	83,000	110	M	4,560	3,600	3,000	Maintenance	No	No	No	Yes	Q S E P
Far West.....	40,000	100	F	4,200	3,600	3,600	No	No	No	No	No	P Q E
	8,500	75	M	4,800	4,500	.....	One Meal	Yes	No	No	Yes	P S E Q
	100,000	80	F	4,800	4,800	4,200	No	No	No	No	No	E S Q P
Canada.....	24,000	83	M	3,300	3,000	3,000	Car	No	No	No	Yes	S P Q E
Average.....		79		4,713	4,362	3,950						
Average—Male....		81		5,500								
Average—Female..		76		3,760								

S—Satisfaction in hospital purposes. Q—Quality of professional associates.
P—Prestige in community. E—Earnings. J—Job Satisfaction.

children to support." Another man, in a community of 15,000, has this comment on his $3600 salary. "You have too many financial obligations in a community of this size. Too many meetings, too much 'public relations' that I must pay for out of my own pocket."

In spite of this consistent evidence of discontent with the amount of compensation, only seven administrators in this group would leave the hospital field to accept higher pay in another line of work. All the rest, including several who think they are underpaid from every standpoint, intend to stay in hospital work, for better or for worse. "The past several years have tried my soul," says one in a typical comment, "but I think I shall still stick it out." "I have done hospital work for twenty years and am happy in my position," says another. "Being happy in one's work, to me, seems more important than earning a high salary." "I like to help the fellow that needs help," is still another comment, and one says simply, "Institutional work gets in the blood."

"I would leave, though regretfully," writes one of the seven who dissented from the majority view. "Better pay and less tension would make a longer life, and reasonable hours, a fuller life," this administrator adds. Another who acknowledges that he is ready to toss in the sponge explains his feelings this way: "I am tired of fighting the board for money and better standards, employes' salaries and decent equipment. Tired of grasping selfishness of a large part of the staff doctors."

At $6500 a year in a 100-bed hospital, a man administrator who would leave his job for higher pay elsewhere points out that he might be forced into such a move for purely economic reasons. "I have to think of my family and the education of my children," he says simply.

Finally, these administrators were asked to evaluate the factors which are the chief motivating forces in their professional lives. Four specific factors were identified on the form they were asked to fill in: (1) satisfaction in hospital purposes, (2) quality of their professional associates, (3) prestige in the community, and (4) earning opportunities. Administrators were asked to rank these in order of importance and add others which they feel are influential motivating forces in their lives.

THE PURPOSE IS IMPORTANT

Overwhelmingly, satisfaction in hospital purposes emerges from the replies as the force that keeps hospital administrators going. In a weighted score based on ranking given the several factors named, satisfaction was first with 348, quality of professional associates second with 161, earning opportunity third with 125, and prestige in the community fourth with 109. The only other motivation that received more than a scattering mention was the gratification that an administrator gets from accomplishing a difficult task.

In their accompanying remarks, the respondents struggled to express their feelings about hospital work. Two of these comments come through as significant: "It's a job to be done," says one man who runs a 100-bed hospital in the Middle West. "I wouldn't want to take a hospital that had no major problems."

"I don't know why anyone goes into hospital work," says another, "but after you're in it, it grows on you until you love it." Supporting a family on $300 a month, this man is in the hospital field to stay.

VOLUNTEER ACTIVITIES

Coupons Did It

Soap flakes coupons from home kitchens have outfitted the diet kitchen and the head nurses' kitchenette at Evanston Hospital, Evanston, Ill. Three years' hoard of coupons by auxiliary members were recently spent in one grand shopping orgy, and now the hospital's special kitchens have saucepans, mixing bowls, frying pans, custard cups, paring knives, and measuring cups in ample quantities. The second vice president of the auxiliary, Marian Carpenter, takes charge of coupon solicitation; she has three receiving stations for coupons, the chief of which is the auxiliary's own gift shop in the hospital lobby.

Nearly New—Always Profitable

Even though it closes its doors during the summer, the Nearly New Shop in Montreal, Canada, is a substantial money-maker. Last year it turned over $5000 to the Royal Victoria-Montreal Maternity Pavilion and $5000 to the Children's Memorial Hospital, with a substantial balance left in the bank to start the fall program.

The Women's Volunteer Services in Montreal, the Royal Victoria's auxiliary board of governors and other volunteers have provided personnel for the follow-up system in both gynecology and obstetrics for the maternity pavilion. The auxiliary board also finances the special medicine fund, which provides drugs for cancer and other patients who cannot afford to pay for the medicines prescribed.

Now They Need a Sitter

A fete on the hospital grounds, June 16, was the means used by the auxiliary of Shadyside Hospital, Pittsburgh, to raise money for redecorating patients' rooms. The admission charge was $1.50 a person. Booths erected on the grounds carried needlework, baked goods, whatnots, garden supplies and books, all donated.

Perhaps members of the Shadyside auxiliary will not turn a deaf ear—auxiliary members don't seem to have deaf ears—to a suggestion from one of the girls in the front office. She says the hospital could use a baby sitter.

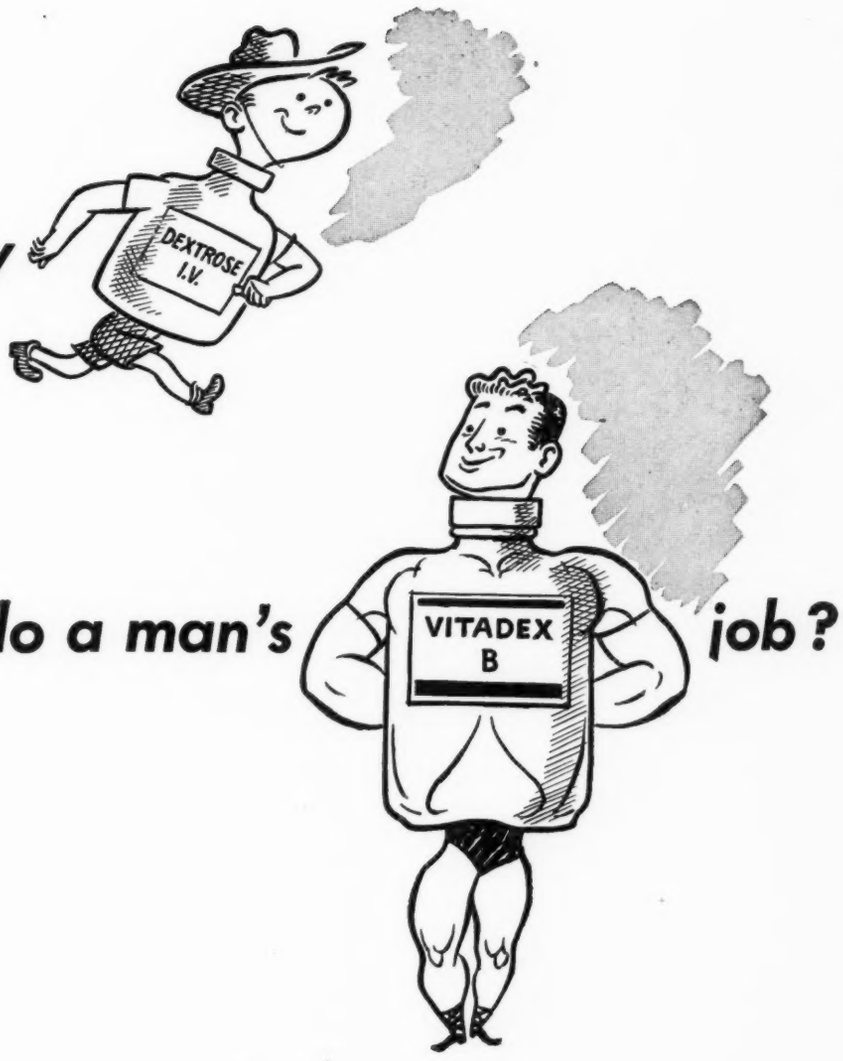
Often visitors have no one at home with whom to leave the baby or preschool child so they bring him along to the hospital. Children are not allowed on the nursing floor so they must wait in the lobby.

House-to-House

The house-to-house canvass, after six years of trial, has become the favorite fund raising method of the women's auxiliary of Hackensack Hospital, Hackensack, N.J.

Last year thirty-nine branches and seventeen committees carried out the canvass; the result was $21,133.08. Contributions made to the codeine, blood plasma and babies' alumni funds, plus interest on bonds, brought the year's grand total to $24,462, an achievement of which Harriet S. Conklin, chairman of the finance committee, and her mother-in-law, Edna B. Conklin, retiring president of the auxiliary, could well be proud.

why send a boy to do a man's job?



DEBILITATED patients need dextrose, certainly. But it's a good bet that their vitamin store is depleted, too.

More and more investigators are realizing that intravenous dextrose *alone* is often not enough to pull debilitated patients over the hump. Sebrell*, for instance, says "By giving glucose, you push up the metabolism and the utilization of those vitamins which are necessary, *without replacing them*. As a result, the suspicion is growing that much of the disability and possibly part of the mortality following surgical operations is due to this effect on a patient with a low vitamin reserve at the time of operation."

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*Sebrell, W. H., Jr., et al: J. Pediat. 22:494-507, April, 1943.

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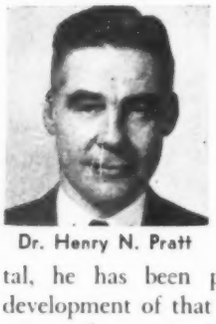
ABOUT PEOPLE

Administrators


Dr. Henry N. Pratt

Dr. Henry Nickerson Pratt has been named director of the New York Hospital, New York City. Now administrator of Memorial Hospital, he has been participating in the development of that center for the treatment of cancer since February 1946. While no definite date has been determined when he will assume his new post, it will be not later than January 1. **Laurence G. Payson,** secretary and treasurer of the Society of the New York Hospital, has been serving as acting director of the hospital since the first of the year, when **Murray Sargent** retired as director.

James C. Gliemmo, formerly administrative assistant at Starling-Loving University Hospital, Columbus, Ohio, is now administrator of Iroquois Hospital, Watseka, Ill.

Leona Penny is the new superintendent of Montgomery County Hospital, Conroe, Tex. She succeeds **Mrs. Coral McCants, R.N.**

Mrs. Erma B. Hubbard, R.N., is the new superintendent of Morrison Hospital, Morrison, Ill. She succeeds **Edna L. Kramer,** who resigned to accept a scholarship in pediatrics at the University of Cincinnati.

H. F. Blum Jr. has taken over his duties as administrator of Danforth Memorial Hospital, Texas City, Tex., following the resignation of **William L. Lockhart.**

Dr. Israel Oscar Weissman, former assistant director of the Jewish Hospital of Brooklyn, N. Y., has been named director of Sydenham Hospital, New York City, the interracially operated institution in Harlem. He succeeds **Dr. Sigmund Friedman,** who resigned in March. Dr. Weissman is a graduate of Columbia University and the Long Island College of Medicine.

Graham F. Stephens, associate director of Barnes Hospital, St. Louis, and associate director of the department of hospital administration of Washington University, has been named administrator of Geisinger Memorial Hospital, Danville, Pa. Mr. Stephens, who succeeds **William L. Wilson,** has been connected with the Toronto General Hospital, Toronto, Ont., and for some time was assistant director of Evanston Hospital, Evanston, Ill. During the war he served in the Royal Canadian Air Force as an administrative officer in the hospital service. For a time following his release from the army, he assisted his father, the late **Dr. George F. Stephens,** at the Royal Victorial Hospital in Montreal. Mr. Stephens is a member of the American College of Hospital Administrators, the American Hospital Association, the Missouri Hospital Association and the St. Louis Hospital Council.


John R. Mannix

John R. Mannix has been appointed executive director of the Cleveland Hospital Service Association, succeeding **John A. McNamara** and **Michael Kelly,** co-directors, who resigned in June. Mr. Mannix has resigned as president of the John Marshall Insurance Company, which he organized two years ago. His successor has not been named.

In taking over the directorship of Cleveland's Blue Cross plan, Mr. Mannix is returning to an area where he took an active part in hospital affairs for many years. He was assistant director of the University Hospitals in Cleveland for ten years before going to Detroit in 1939 to start the Blue Cross plan there. In 1944, he moved to Chicago as Blue Cross director, the position he left two years later to form the John Marshall company.

Mr. Mannix's appointment to the Cleveland position was announced July 21 and became effective August 1.

Richard C. Aldinger has been promoted from assistant administrator to administrator of Columbus City Hospital, Columbus, Ga.

Stanley Ferguson, for the last ten years superintendent of Chicago Lying-In Hospital, a unit of the University of Chicago, has resigned to accept the position of administrator at City Hospital, Cleveland, succeeding **Dr. Charles Dolezal.**

Carl D. Jeffries has resigned as superintendent of C. H. Buhl Hospital, Sharon, Pa., after twenty-one years' service.

Edward G. Phoebus Jr. has accepted the post of assistant administrator at Garfield Memorial Hospital, Washington, D.C. Mr. Phoebus was formerly purchasing agent and assistant to the superintendent at Maryland General Hospital, Baltimore.

Dr. Aims C. McGuinness has been appointed director of Children's Hospital of Philadelphia.

Kenath Hartman is now evening superintendent at Wesley Memorial Hospital, Chicago. He resigned from Mount Sinai Hospital, Chicago, where he was administrative assistant.

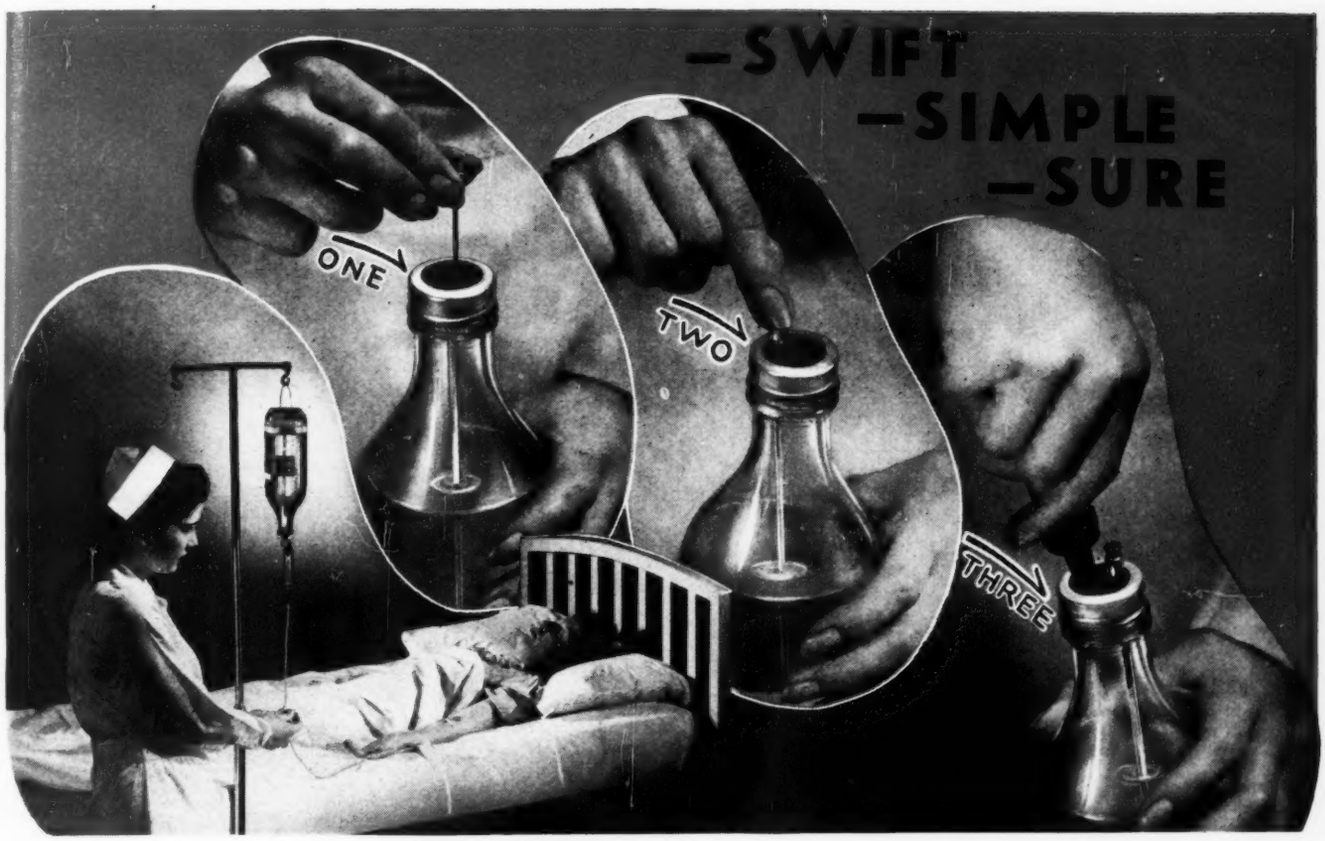
Mrs. L. Gwyn Adams, R.N., has succeeded **Mrs. Clara E. Burke** as superintendent of Nightingale Hospital, El Campo, Tex. Mrs. Adams was formerly associated with Kleberg Hospital, Kingsville, Tex.


Helen Lueck

Helen Lueck has been appointed administrator of St. Luke's Hospital, St. Paul, to succeed **Martha Borge,** who resigned. Miss Lueck was graduated from the course in hospital administration at the University of Minnesota and served her internship at the University Hospitals, Minneapolis.

Richard W. Trenkner has been appointed assistant director of Charles T. Miller Hospital and Amherst H. Wilder Dispensary, St. Paul. Mr. Trenkner recently received his master's degree in

(*Continued on Page* 152.)



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CHRONIC DISEASE

The Nation's Next Problem in Hospital Care

CLAUDE W. MUNGER, M.D.
Director, St. Luke's Hospital, New York City

DURING the last twenty-five years this country has been slowly awakening to the fact that chronic diseases now constitute our principal health problem. They are responsible for far more illness and disability than are acute diseases and are the cause of more than half of all deaths. The great achievements that medicine and public health have made in controlling acute diseases, and thereby prolonging life, have contributed to a steady increase in the proportion of older persons in the population. Chronic disease may occur at any age, but it occurs more frequently with advancing age and is most prevalent in middle life and old age. Its effects are most serious when it occurs in the most productive years of life.

BEGIN AND DEVELOP SLOWLY

The term chronic is generally used to designate diseases that, as a rule, begin gradually and develop slowly and either become progressively worse, or, if arrested, leave some physical handicap. The acute type of disease, on the other hand, as a rule begins suddenly, runs a self-limited course and results in either death or recovery.

Tuberculosis and mental disorders are diseases of the chronic type, but they are not usually included in discussions of the chronic disease problem because community organization in these fields has been undertaken on a large scale by state governments and national and local voluntary organizations.

There is no comparable organization for community planning to meet the problems of other chronic diseases, although some progress has been made in respect to certain diseases—notably cancer, heart disease, and orthopedic conditions in children. The conditions included under the term chronic disease include arthritis, diseases of heart and arteries, diseases of kidneys and liver, organic affections of the nervous system, cancer, nontuberculous diseases of the lungs, diabetes and other endocrine and metabolic disturbances. There are also natural infirmities of senescence not due to chronic disease which often call for a similar type of care, so that plans for long-term care of the chronically ill should include the infirm aged.

Chronic illness is sometimes defined in terms of its duration, usually as a condition lasting at least three months, with an indefinite prognosis. In statistical studies in which the number of chronically ill persons in a given population group is to be enumerated, it is necessary to adopt an exact arbitrary definition of this kind. In measures for the care of chronic disease, the differentiation between acute and chronic cannot be based entirely on the duration of the illness but should be made according to the nature of the disease.

A person with a chronic disease may recover from his immediate disability in a few weeks under good medical treatment, although the condition from which he suffers is not entirely eliminated and may manifest itself in occasional exacerbations. On the other hand, a person with an acute disease may have a long, drawn out illness of many months and, in some instances, may develop a chronic condition.

The problem of chronic disease is one of immense proportions and great complexity. It concerns persons in every age group, at all income levels, and ramifies into every part of our industrial and social life. There is hardly an individual who is not at some time concerned with it in his personal life, either directly or indirectly. It occurs twice as frequently in the lower income groups as in the higher. But its consequences may be even more serious for persons in the middle income brackets, inasmuch as the services provided by the community for those who cannot pay for medical care are for the most part not available to those who can pay something.

MANY DIFFERENT TYPES

The complexity of the problem is indicated by the number of different types of disease included. For some of these conditions, such as rheumatic heart disease in children, orthopedic disorders, and cancer, special facilities are required. In each disease group all degrees of illness are found, ranging from a condition that under proper treatment causes practically no inconvenience to one that results in complete incapacity. Chronic diseases are in themselves more complicated to deal with than are acute diseases, because psychological and social factors play an even larger part in their causation and treatment.

To meet the needs of persons suffering from various types and degrees of chronic disease, a great variety of services and facilities and of trained personnel is needed. The treatment, rehabilitation and long-term care of those who are incapacitated require the development of extensive community and institutional resources, under both governmental and voluntary auspices. Underlying the whole problem is the need for medical investigation of the causes and treatment of chronic diseases on a scale comparable to the study of acute diseases in the past. Similar expenditures in this field may be expected to bring equally beneficial results.

Condensed from a study made for the Federation of Social Agencies of Pittsburgh and Allegheny County.

The failure of the public and the medical profession in the past to recognize the need for community planning for control and care of chronic diseases has brought us into a situation of great gravity. Throughout the country, state and local authorities are faced with the problem of large numbers of chronically ill persons for whom they are unable to provide even the most elementary protection. Public and voluntary hospitals are forced in most instances to turn away the sick who need prolonged treatment. For many years, leaders in medicine and public health have given warning of the serious consequences of neglecting the chronic diseases.

Dr. Alfred E. Cohn, in an address in 1922, said, "Chronic diseases present problems admittedly the most difficult in the realm of medical biology. They must nevertheless be met if society wishes seriously to alleviate its own suffering." He called chronic diseases "the real scourges to the happiness, dignity and comfort of mankind." Dr. George H. Bigelow warned that "the problem of chronic diseases will not be downed" even though "health officers, legislators and physicians may prefer to turn their backs on it, vaguely hoping that it will solve itself."

The federal government has recognized the urgency of the problem in the National Health Survey, 1935, in the Vocational Rehabilitation Act amendments of 1943, and in Title V of the Social Security Act, 1936. Public Law 725, the Hospital Survey and Construction Act, passed in 1946, recognizes this need, in that its scope was made to include the financing of hospital construction for chronic as well as acute illnesses. The United States Public Health Service has stimulated studies in gerontology, the scientific investigation of the aging process in man.

Many states and cities are now engaged in surveys and programs for improving the care of the chronically ill. Committees of the American Hospital Association, the American Public Health Association, and the American Public Welfare Association are engaged in studying means of improving the situation on a national scale.

A *Journal of Gerontology* was recently established, under the direction of a distinguished editorial board. The impetus given to rehabilitation of the handicapped and disabled throughout the country by the studies and plans of the Baruch Committee is beginning to be felt in widespread public recognition of the right of the chronic disease patient to receive constructive treatment.

Incidence of Chronic Disease in the U.S.*

AGE IN YEARS	RATE PER 100 PERSONS
All ages	177.0
Under 5	34.2
5-14	68.3
15-24	82.9
25-34	159.2
35-44	221.0
45-54	273.4
55-64	344.3
65-74	467.1
75-84	513.6
85 and over	602.3

Number of Chronic Invalids in the U.S.*

AGE IN YEARS	RATE PER 1000 PERSONS
All ages	11.4
Under 5	1.9
5-14	3.1
15-24	4.5
25-34	5.6
35-44	10.4
45-54	15.7
55-64	27.8
65-74	53.5
75-84	72.7
85 and over	106.2

Distribution of Chronic Disease Patients in the U.S.*

AGE IN YEARS	PER CENT
Under 15	7.9
15-24	8.4
25-44	35.1
45-64	33.0
65 and over	15.6
Total	100.0

*From the National Health Survey, 1935-36.

The most comprehensive data on the prevalence of chronic diseases are found in the National Health Survey conducted by the United States Public Health Service. In this survey 800,000 families in eighty-three cities and twenty-three rural areas of nineteen states were visited.[1] Care was taken to select a representative sample in each locality. Nearly 18 per cent of the population surveyed, almost one in every five persons, had a chronic disease, a permanent impairment, or a serious defect of vision or hearing. More than 1 per cent were chronic invalids.

The rate of chronic disease and the number of chronic invalids per hundred of the population in different age groups, as found by the National Health Survey, are shown in the accompanying tables. As tuberculosis and mental diseases were included when found among persons living in the families canvassed, these rates are somewhat higher than they would be if confined to the other chronic diseases.

These figures show that "the problem is one of the productive years of life. Fully 70 per cent of the cases occur in persons under 55 years of age. Over one-half of persons permanently disabled and almost 30 per cent of those who died from chronic disease were under 55 years of age."[2]

Extensive surveys of the prevalence of chronic illness have been made in Massachusetts[3] and in New York City;[4] and similar surveys have been made elsewhere. In a study made by the United States Public Health Service in the Eastern Health District of Baltimore,[5] in which every family surveyed was observed for a year, 9 per cent of the population aged five years of age and over was found to be suffering from a chronic disease, including tuberculosis and mental disease.

The results of these various surveys are not strictly comparable, since different methods of enumeration have been used and since tuberculosis and mental diseases have sometimes been included, and one or both of these conditions have sometimes been excluded. From comparison of the findings of the National Health Survey and other studies it may be estimated that approximately 10 per cent of the population suffers from chronic diseases, excluding tuberculosis, mental diseases, and physical impairments due to causes other than chronic disease, and that 1 per cent of the population are chronic invalids unable to care for themselves without assistance.

It is impossible to estimate with even approximate accuracy the proportion of persons with chronic disease who need institutional care, home med-

(*Continued on Page* 114.)

[1]The National Health Survey, 1935-36—The Magnitude of the Chronic Disease Problems in the United States. Division of Public Health Methods, National Institute of Health, U.S. Public Health Service, 1938.

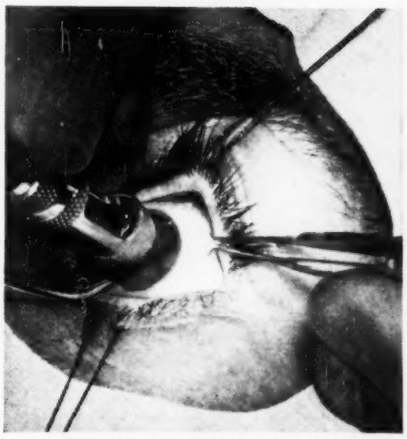
[2]Boas, Ernst P., M.D.: The Unseen Plague: Chronic Disease. New York: J. J. Augustin, 1940.

[3]Bigelow, George H., M.D., and Lombard, Herbert L., M.D.: Cancer and Other Chronic Diseases in Massachusetts. Boston: Houghton Mifflin Company, 1933.

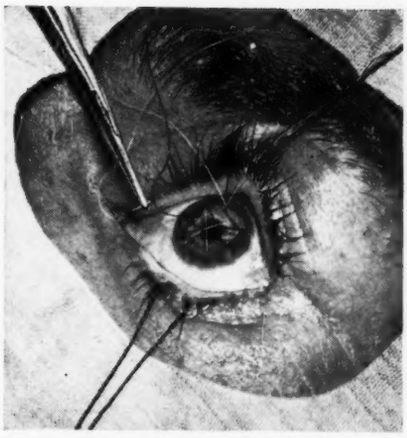
[4]Jarrett, Mary C.: Chronic Illness in New York City. New York: Columbia University Press, 1933.

[5]Downes, Jean: Findings of the Study of Chronic Disease in the Eastern Health District of Baltimore. The Milbank Memorial Fund Quarterly, October 1944.

The graft removed from the donor eye. ▲

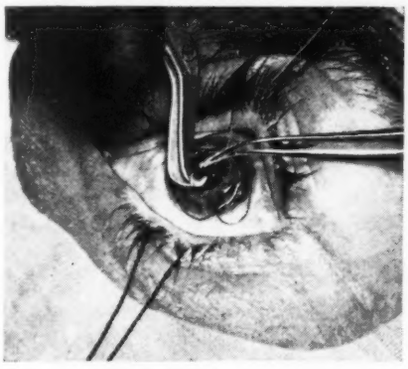


Patient's cornea outlined with the trephine. ▲

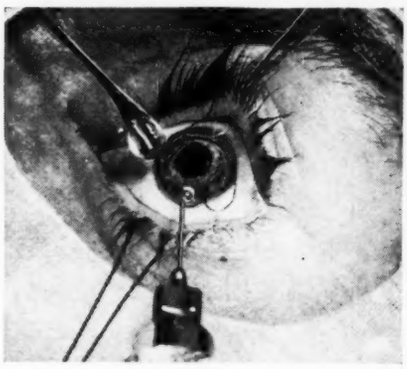


Bridging sutures placed around cornea. ▲

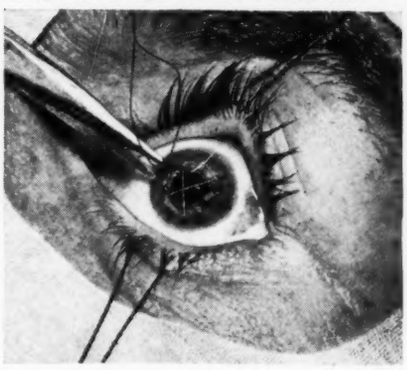
Button removed with trephine and scissors. ▼



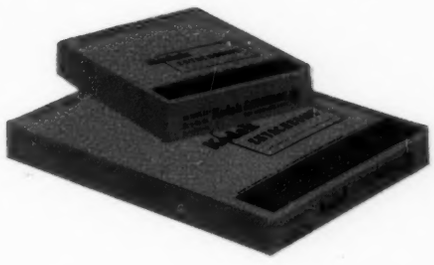
Donor graft shown ready for insertion. ▼



Operation completed with the sutures tied. ▼



Reproduced from color photographs of corneal grafting operation, performed under the auspices of the Eye-Bank for Sight Restoration.



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MEDICINE AND PHARMACY

ARE YOUR PATIENTS PROPERLY CARED FOR?

A medical audit, or analysis, helps the staff answer this question

REV. W. C. PERDEW
Administrator
Bronson Methodist Hospital
Kalamazoo, Mich.

THE value of an annual financial audit has long been recognized by hospitals as a means of determining the accuracy of accounting practices, the efficiency of personnel, and the improvement or deterioration in capital position. There are few hospitals today which do not have an annual audit of their financial transactions.

It is of far more importance to the patients that the hospital have a medical audit which might disclose the accuracy of diagnoses, the adequacy of medical care, and a standard by which to judge the improvement or deterioration in the quality of medical practice.

NOT AN EXACT SCIENCE

Unfortunately, medical practice is not an exact science. Dollars and cents are subject to mathematical laws which do not apply to the diagnosis and treatment of disease. The quality of medical practice depends upon the observation and classification of a multitude of obscure facts, the interpretation of those facts in the light of a vast body of knowledge which has in it great gaps of mystery and which no one individual is able completely to master.

An appraisal of the accuracy of medical care cannot be arrived at by the addition and subtraction which form the processes of the financial audit. The quality of medical care depends too much upon the soundness of human judgments which at best must be based on fragmentary knowledge and must therefore allow for a considerable margin of error.

From a paper presented at the Tri-State Hospital Assembly, 1948.

Nevertheless, the growing public interest in good medical care has resulted in a search for some method of evaluating a given number of hospital cases to answer the question "Were these patients properly cared for?" Hospital administrators and governing boards, charged with the responsibility of medical staff appointments, recognize that they can have no really impartial method of judging the merits of the individual doctor without some more nearly accurate means of measuring the quality of his work than rumor or gossip. While most hospitals with organized medical staffs do depend upon medical staff recommendations as the basis for making staff appointments, frequently members of the medical profession are reluctant to withhold such a recommendation unless the work of the individual in question is outrageously inadequate.

In our hospital a series of charges and countercharges made by staff members against one another, together with the desire of our trustees to assure themselves that the appointments being made to the medical staff would result in adequate medical care to the patients, led to the development of a plan for a medical audit. We did not call it a medical *audit,* since an audit ordinarily is an examination made by a person who is not a member of the working organization. We preferred the term "medical analysis."

MEMORANDUM SUBMITTED

As a basis for discussion, the following memorandum was prepared by the administrator and submitted to the board of trustees of the hospital and to the executive committee of the medical staff.

"1. The primary purpose of medical staff organization is to maintain a high standard of medical care and to improve it where possible by the self-education of the medical staff through the constant study of its own work in the hospital with special attention to matters in which there is need for improvement.

"2. A medical analysis, faithfully maintained, would constitute a scientific method of discovering specific points of both weakness and strength. Occasional individual instances of questionable management of a case are not sufficient as a basis for judging a doctor's competency when his staff appointment is under consideration.

"3. The primary purpose of such a medical analysis should be educational

rather than disciplinary. It is true, however, that machinery for disciplinary action already exists in the medical staff by-laws and can be used if the medical analysis should reveal gross and persistent violation of sound medical practice.

"4. So far as possible the medical analysis should be based on factual data only in order to reduce to the lowest possible degree the element of personal opinion or bias."

COMMITTEE DEVELOPED PLAN

The memorandum was approved by the staff committee of the board of trustees and by the medical board. The chief of staff appointed a committee of five doctors with the hospital administrator to develop the proposed plan and put it into operation. The hospital pathologist was the chairman of the committee.

Three analysis ledgers were prepared, one for surgical cases, one for medical cases, and one for obstetrical cases, each having the ledger sheet designed according to the needs of the service concerned. The pediatric service did not have a ledger, its cases being divided among the other three.

For several years the medical staff has had a committee of three doctors, known as the medical record committee, which reviews all completed charts. Members are appointed by the chief of staff in rotation. The first step in the medical analysis was for the medical record committee to enlarge the scope of its examination to include an evaluation of the record on the following points:

1. Does the preliminary diagnosis coincide with the final diagnosis?
2. Does the pathological report confirm the preliminary diagnosis and justify the surgery?
3. Was adequate laboratory and x-ray work done?
4. In medical cases, was the treatment adequate?
5. Is the medical record satisfactory?

A mimeographed memorandum form is fastened to each chart by the medical record librarian. The medical record committee records its evaluation of the aforementioned points on this memorandum. A clerk in the medical record office then copies these evaluations into the analysis ledger, together with the necessary factual items which are taken direct from the medical record itself.

Rotation of the membership of the medical record committee at three-month intervals minimizes personal bias in evaluating the records of the individual doctor.

Let us now examine the ledger sheet developed for the surgical service. Each doctor has a sheet of his own. He is designated by a code number which is known only to the clerk who makes the entries in the ledger. This makes it possible to obtain an impartial evaluation of the work of each doctor as recorded in the ledger, whether that evaluation is made by a committee of the medical staff, the chief of the clinical service, or by outside consultants.

The first column contains the hospital number. This entry is to make it possible to go directly to the medical record, if the person making the summary of the work of any doctor has a question about any cases. It should be borne in mind that the ledger is not intended to be a substitute for the chart itself but is merely a summary of certain facts and evaluations to indicate the general characteristics of a doctor's work. If the statistics should indicate that some aspect of a doctor's work was greatly at variance with the work of the clinical service as a whole, a detailed review of his charts would be indicated.

The sex and age of the patient are entered, inasmuch as they are modifying factors which aid in the interpretation of the case summary.

The days' stay tells something about the quality of care. A high average stay or too short a stay would raise a question as to adequacy of treatment. A doctor who takes twice as long to bring his diabetics under control as does the rest of the staff may need the attention of the chief of internal medicine.

A comparison of the preliminary or preoperative diagnosis with the final diagnosis may indicate the doctor's degree of diagnostic accuracy, which is of the utmost importance in the care of the patient and the control of unnecessary surgery.

Whether the pathological report confirms the preoperative diagnosis and justifies the surgery may be the most important single item in the surgical analysis ledger. It reveals, more accurately than any other method, whether the surgery was done to relieve a pathological condition. This column presupposes (a) that all tissue removed is routinely transmitted to the pathological laboratory, and (b) that the pathologist is well trained, honest and courageous.

In filling in this column in the ledger, a check indicates a positive finding, a zero a negative finding, and a zero with a line through it shows that the tissue has been examined but does not answer the question as to whether the operation was performed to relieve a pathological condition. For example, in a presacral neurectomy, the report stated that the specimen was nerve tissue, showing that a neurectomy had been done, but that was all. No pathological report is made for tonsillectomies or adenoidectomies. Some minor surgery and most traumatic and orthopedic surgery naturally provide no tissue on which a report can be made and thus are not subject to this mode of evaluation.

The operation performed is stated and can be compared with the final diagnosis to determine whether it was the treatment of choice for the condition indicated.

Morbidity is always an index of the quality of treatment and definitely points the way to study of the technics that are being used if it is above the normal expectancy.

DO THEY USE DIAGNOSTIC AIDS?

Whether the diagnostic aids provided by the clinical laboratory and the x-ray departments have been adequately used is an important index. Modern medical practice requires the use of many diagnostic tests to provide the physician with the facts necessary to accurate diagnosis and scientific management of the case.

The number of consultations is also an index as to the quality of medical care. Whenever there is a free sharing of knowledge and pooling of judgment, both the attending physican and the patient benefit.

The results of treatment are recorded under four headings: "Recovered," "Improved," "Unimproved" and "Died." The attending physician makes his own evaluation on these points, and they are thus not quite as accurate a basis for judging the quality of care as are some other items, such as the pathologists report. However, one of the four items is exempt from this criticism: the optimism of the physician exerts no influence on the record when the patient dies.

A check mark is used to indicate the condition on discharge, and in case of autopsy, a capital A is placed in the "died" column. A large percentage of autopsies is a significant indication of a truly scientific attitude of a doctor

toward his own work and is thus an important indication as to the quality of his practice.

The final section gives the evaluation of the quality of the medical record itself as to the history, physical examination, progress notes and operative record. Each of these should be comprehensive, definite and clear so that another doctor, reading it, can understand the reasons for the diagnosis, what was done to remedy the condition, and what results were obtained.

In the medical analysis ledger, the same considerations apply to the doctor's code number, hospital number, the sex and age of the patient, the length of stay, the preliminary and final diagnosis, the adequacy of laboratory and x-ray work, the complications, the consultations, results of treatment, and unsatisfactory records. In addition, the treatment given is evaluated although it usually is not criticized by the medical record committee unless it is grossly inadequate.

SEVERAL ITEMS ADDED

In the obstetrical analysis, the same considerations apply as have previously been noted as to code number, hospital number, age, days' stay, morbidity, consultations, results and records. But several other items are listed which apply specifically to obstetrical cases. Para and gravida are modifying factors in obstetrical cases and must be taken into consideration in evaluating the care given.

The average length of labor, if a sufficient number of cases is taken, is an index. If it is consistently above the average, it suggests the neglect of possible procedures, and if it is too far below the average, it suggests that the doctor may be forcing labor too rapidly for the sake of his own convenience rather than the welfare of his patients. If labor is induced, that fact is entered in this column. Too generous a resort to pituitrin or other means of inducing labor should be carefully scrutinized.

The type of delivery, whether spontaneous, low forceps, mid or high forceps or cesarian section, is recorded. Frequent use of mid or high forceps or resort to cesarian section raises a question of the quality of medical care being given, or of unnecessary operation.

A comparison of the number of lacerations with the number of episiotomies is an index as to procedures customarily used.

Now as to the benefits derived from this study. Much light has been thrown on the quality of medical practice in our hospital although the study is far from complete.

Frankly, we were pleasantly surprised. We had expected some rather unfavorable situations to be revealed, judging by the many outspoken criticisms, as well as whispered rumors, which had been freely circulated. This study has helped the morale of the medical staff. Although more doctors may be doing surgery than may be considered wise, most of them seem to be voluntarily limiting themselves to procedures they are capable of handling. No evidence was discovered of any substantial amount of unnecessary surgery, assuming that an average of 10 per cent of cases in which the pathological report fails to confirm the preoperative diagnosis is not exorbitant.

However, the study does disclose information which may be used to set up definite goals for improvement. The number of consultations is generally inadequate by modern standards; and we note that the best trained doctors, who need consultation the least, seek it most frequently. The analysis also shows the need of certain doctors to give more careful attention to their medical records. The patients of a few are having too many complications and infections.

Each of these doctors can be given individual attention by the chief of surgery, now that we have some factual indications as to the point at which improvement is needed. If no other benefit were to be derived from the analysis, we believe this definite outline of deficiences to be corrected would make it worth while.

An incidental benefit is that undoubtedly each doctor has tended to do his work with greater care since he knew that it would be subject to impersonal scrutiny. And the patient gets the ultimate benefit.

In appraising the work, it would only be fair to mention the difficulties encountered. We found keeping up the ledgers a considerable chore about which our record room personnel frequently complained on the ground that many of the entries were a duplication of material also being entered in the standard indexes. For a while one of the clerks took a short cut by omitting the preoperative diagnoses, so that it was impossible to make a proper summary and comparison on this point. It should also be noted that many doctors did not have enough cases on the service to permit of drawing conclusions concerning the quality of their work. A man might have a mortality rate of 25 per cent which looks bad until we find that he had only four cases. For doctors who do only a small amount of work, a long time is required to arrive at an accurate evaluation of their work.

Out of this experiment we have concluded that there is real value for the hospital, the medical staff, and the patient in this kind of activity. But the amount of labor involved is so great that we are seriously thinking of discarding the ledger plan and simply adding a few more columns to the standard indexes. For example, we can use the regular disease index form by adding columns for diagnosis comparison, pathology report, consultation and unsatisfactory record, and by using a check mark or a zero in each column for positive or negative.

UTILIZE MATERNITY REGISTER

For obstetrical cases we can utilize the maternity register by merely adding columns for consultation, days' stay, autopsy and unsatisfactory record. The obstetrical nurses keep up the maternity register, but the record room could add the information required by these columns and do the tabulating at the end of the survey period. Thus, the same information could be recorded as in the ledger with little more labor.

Perhaps the most important question of all is, What will be done with this information after it has been gathered? We can answer that question better a year from now than we can today. However, we do expect that it will be useful to the chiefs of the clinical services in supervising and regulating the work of doctors assigned to their services.

It will enable the medical staff to set goals for itself where the analysis shows that specific improvements are needed. It will be useful to the trustees in making medical staff appointments and in appointing the chiefs of the clinical services, inasmuch as it tends to reveal the actual results obtained, which in themselves may be considered a more satisfactory basis for judging quality of medical care than are membership in learned societies, certificates of examinations successfully passed, or rumor or gossip based on isolated cases.

We believe this experiment in medical audit has taught us something and we hope to profit by it.

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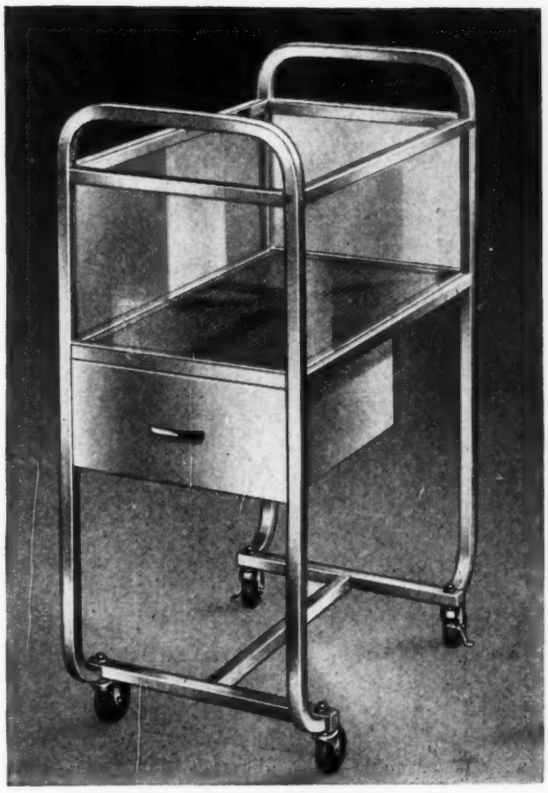

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NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

POLYHYDRIC ALCOHOLS IN MODERN MEDICINE

PRESENT interest in polyhydric alcohols follows two general lines. The first is the result of the application of the properties of these agents to industry and medicine on a scale hitherto unparalleled. A corollary to this has been the increase in knowledge of the toxicity of these agents, enabling a more scientific appraisal of their potentialities and limitations. A toxicological interest in the glycols exists primarily as a result of man's almost inevitable misuse of pharmacologically active agents.

ONE OF EARLIEST USED

Certainly, one of the earliest polyhydric alcohols to be used in medicine as a vehicle for oral drugs was glycerin or glycerol. Taken orally this polyhydric alcohol is nontoxic and is synthesized in the body to glucose. In a concentration of 40 to 50 per cent, glycerin adds body to medicaments and also prevents bacterial growth. If given parenterally, however, glycerol produces hemolysis of the red blood cells which results in hemoglobinuria. Thus it cannot be used as a vehicle for the parenteral administration of drugs. All of the acetyl derivatives of glycerol will also, and to a greater extent, produce fatal hemoglobinuria. Myanesin, which is an o-tolyl alpha ether of glycerol, will also produce hemolysis when used in an effective paralyzing dosage.

In 1937 an elixir of sulfanilamide was marketed which, instead of containing alcohol as the solvent, employed diethylene glycol. From acute toxicity studies published in the literature, diethylene glycol should not have been toxic. However, on chronic oral administration in man and dogs, this polyhydric alcohol produces a marked edema of the epithelium of the kidney tubules which is sufficiently persistent in man to produce uremic death. As a result of the publicity which resulted from more than 75 uremic deaths following the oral ingestion of the "Elixir of Sulfanilamide" the passage of the 1938 Food, Drug and Cosmetic Act was demanded by an aroused public. Accidental mass poisonings may still occasionally occur but the Food and Drug Act should now prevent such negligent mass homicide.

Newer Glycols: The versatility of the polyhydric alcohols as solvents has long been appreciated, and it is along this line that other new developments have occurred. Propylene glycol, which is a nontoxic parenteral solvent, has been employed as a solvent for vitamin preparations used extensively in infants, and numerous other pharmaceutical preparations. McGavack and Vogel advocate its use as a solvent for desoxycorticosterone and have shown its innocuous nature on intravenous and intramuscular administration. Veterinary pentobarbital sodium is stabilized with 10 per cent propylene glycol. Solutions containing 35 per cent propylene glycol are self-sterilizing, but because of slight hemolysis and local irritation, 10 to 15 per cent propylene glycol is the maximal concentration used for intravenous administration. Propylene glycol is harmlessly oxidized in the body.

RECOGNIZED RECENTLY

It has only been in the past few years that the polyethylene glycols (polymers of ethylene glycol) were recognized as being useful pharmaceutically. Following the demonstration by Smyth et al. in 1942 that the compounds known as Carbowax 1500 and 4000 were of low oral toxicity and nonirritating when applied topically, Friedman showed that the former compound was an effective solvent for fat-soluble hormones, to be used in experimental studies. Clinically, Carbowax 1500 enjoys its greatest use as a vehicle for various dermatologic ointments. It has the advantage of being wax-like but completely water-soluble and relatively nonirritating.

Toxicology: In addition to the toxicity studies which were undertaken in conjunction with the new developments mentioned, one problem of a toxicologic nature remains as yet unsolved and apparently is increasing in importance. This problem involves the ingestion, whether intentional or accidental, of certain types of antifreeze preparations, the essential constituent of which is ethylene glycol.

REPORTS PUBLISHED IN 1930

As early as 1930 reports of acute ethylene glycol intoxication were published. With more widespread use of the antifreeze agent, more reports of acute intoxication were made known. Most recent reports include a series of eighteen fatal cases reported by Pons and Custer in 1946, three by Widman in 1946, and sporadic cases by Milles, Jensen and other observers. From this it is plainly seen that a real problem exists in the diagnosis and treatment of this condition.

The exact mechanism of death in ethylene glycol poisoning is as yet undetermined. Because of the presence of oxalate crystals in the kidney tubules of fatal cases, associated with severe hemorrhagic nephrosis, it was felt that the mechanism was perhaps as follows: ethylene glycol was oxidized to oxalic acid which then precipitated in the tubules. The crystals damaged the tubular epithelium and kidney failure resulted.

(*Continued on Page* 92.)

Recent work has challenged this concept. Pare and Custer feel the essential element is a chemical meningitis, while Hagemann and Chiffelle point to widespread capillary damage in the brain, kidney, lung and heart as the primary element in the pathogenesis of poisoning. Clinically, the patient presents a picture of severe CNS depression beginning several hours after the ingestion of the glycol. Reflexes are unobtainable, the Babinski may be positive and ocular paresis and paralysis of the soft palate may be seen. Repeated bloody emesis commonly occurs, and urinary output may decrease, progressing to anuria with an elevation of NPN and death in uremia. Hypertension, acidosis, coma, convulsions and death may occur, however, without evidence of renal failure.

Treatment is in general ineffective. It consists of gastric lavage, intravenous fluids, sodium lactate and oxygen. Kidney decapsulation and such heroic measures as peritoneal irrigation and the use of the artificial kidney may be attempted. Milles has suggested the use of calcium salts intravenously, but the efficacy of this treatment is as yet unproved.

Aerosols: Perhaps the most significant development has been in the realm of air disinfection by the use of finely vaporized aerosols. It has been known for some time that ethylene glycol and propylene glycol had definite germicidal action, but it remained for Robertson et al. in 1941 to demonstrate that when finely dispersed in a concentration of 161 parts per million these compounds were capable of sterilizing an atmosphere containing 200,000 Staphylococci albus per liter of air.

This stimulated extensive research to determine (1) the effect of these agents against other microorganisms, (2) the engineering problem which would have to be solved in the application of these agents to practical use, and (3) whether or not other agents, by virtue of lesser toxicity and greater effect, might be still more applicable to such a use. To date all of the data are not yet available, and, as a result, these agents are not enjoying widespread use, but inasmuch as they may play a large rôle in air disinfection in the future, an evaluation of their present status is in order.

As early as 1941 it was shown that triethylene glycol (TEG) was effective in the sterilization of air in concentrations one-twentieth or less than the effective concentration of propylene glycol. Attention has therefore centered around TEG and dipropylene glycol, both of which have desirable germicidal properties and are relatively nontoxic.

Investigation showed that when it was finely dispersed in concentrations ranging up to 100 per cent saturation of the atmosphere, TEG was colorless, odorless, nonirritating, and nontoxic. No deleterious effects on room furnishings were noted either. It is present as a fine mist in concentrations approaching 100 per cent saturation, but inasmuch as it is completely effective at 50 per cent saturation, this is not a practical limitation.

TEG aerosol is effective against pneumococcus, streptococcus, staphylococcus, and influenza virus. Its effectiveness is diminished, however, by desiccation of bacterial particles, so that in areas where dust is continually being raised the potency falls rapidly. This is evidenced most clearly by the fact that only 75 per cent sterilization of air can be achieved in inhabited rooms, whereas under controlled lab-

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oratory conditions 100 per cent sterilization is produced with ease.

Vaporization may be accomplished by one of two methods. The glycol may be nebulized by forcing it through narrow apertures under high pressure. An alternate method involves the use of heat. The boiling point of TEG is 290° C. but decomposition takes place above 127° C., so that to accomplish adequate vaporization the glycol must be heated below that temperature over a fairly large surface.

Portable vaporizers, adequate for rooms up to 20,000 cubic feet, employing heat have been described by Olson, Biggs and Jennings. Inasmuch as drying of bacteria diminishes the effect of TEG, the relative humidity of the room must be maintained at a certain optimal level. At present it is felt that this level lies between 35 and 55 per cent. The simplest means of accomplishing this is the vaporization of water and TEG together, in certain definite proportions, depending on the needs of the room.

Continuous dissemination of the aerosol is necessary, inasmuch as air in inhabited rooms is continually being recontaminated and glycol is lost because of air exchange and condensation. In addition, more time is required to kill desiccated organisms. Some means for effective circulation is also needed. In rooms equipped with air conditioning units, TEG can be atomized and mixed in definite proportions with the air in the blower system. In smaller rooms an oscillating fan may be adequate.

Inasmuch as the aerosol has no effect below 25 per cent saturation and is not optimally effective below 50 per cent saturation, a method of synchronizing the output of glycol with the variations in concentration in various parts of the room is necessary. The most effective device available at present is the glycostat, described by Puck et al. This device is extremely sensitive to small variations in concentration of TEG. It is connected electrically with the vaporizer and controls the output of the aerosol in much the same manner as a thermostat controls the output of heat from a furnace. The glycostat is most applicable to large rooms employing a duct system of air conditioning. In small rooms it is recommended that the aerosol be used in concentrations producing a fine mist, so that its presence can be detected.

EFFECTIVENESS OF TEG

In the last six years, Hamburger et al., Puck et al., Harris and Stokes, Biggs and Jennings, and many other investigators have demonstrated the effectiveness of TEG in reducing air-borne infection among personnel in military hospitals and barracks, and children's hospitals. They also demonstrated the innocuous nature of the glycol and the need for consideration of the aforementioned factors in dissemination if consistently good effects are to be achieved.

TEG, in the future, will probably have its greatest application in the sterilization of air in areas in which the population is constant, such as hospital wards where patients are not ambulatory. It also can be used in acute emergencies in crowded wards, to prevent epidemics of air-borne infection. Its value in schools, trains and other situations in which an individual spends only part of his time has not been demonstrated, although conceivably, if TEG were used in enough public places, the overall incidence of air-borne infection might decrease.—DANIEL A. LANG.

FOOD SERVICE

Conducted by Mary P. Huddleson

SOYBEANS IN PEACE OR WAR

MABELLE S. EHLERS

Professor and Head, Department of Institution Administration
Michigan State College of Agriculture and Applied Science, East Lansing, Mich.

SOYBEANS and soy products, used for thousands of years in the Orient but practically unknown to the Occident, received some attention in the United States during World War I. They made little headway, however, until World War II came along. By that time, more varieties of the bean were available, as well as more of the many products that can be made from it, and so it was much more widely used. Soybeans have a definite contribution to make to our food supplies and could be used to advantage by many institutions during peace or war.

HAVE HIGH PROTEIN CONTENT

Soybeans are an excellent source of inexpensive protein. The mature, dry beans have a larger protein content (around 40 per cent) than the green beans, which contain about 12 per cent, according to Sherman and Albrecht. (1) They contain a large amount of fat, 16.5 per cent for the dry beans and 5.2 per cent for the green beans. (1) Flour made from soybeans has approximately the same nutritive value as casein, according to Barnes and Maack. (2) They also say that soy protein is apparently adequate for the growth and maintenance of man.

Harris, Clark and Lockhart (3) found that a bread containing 2.3 per cent skim milk solids and 3 per cent full-fat soy flour was superior in protein content to a bread containing 6 per cent skim milk solids. Volz, Forbes, Nelson and Loosli (4) found that the biological value of soy flour bread was about 10 per cent higher than that of white bread, even when only 5 per cent soy flour had been added. Other workers have obtained similar results. Soy proteins seem, then, to serve as valuable supplements to those of wheat and milk.

The high protein content of soy has been utilized by commercial processors who make a "cutlet" and a "steak" from soy and cereals. A "gravy," several meat-flavor sauces, and the well known soy sauce are commercial products that are also available. Soy "cheese," the Chinese tofu, is available in some places as is commercially processed dried or canned soy "milk."

Besides its protein value, the soybean provides certain minerals and vitamins. According to Sherman and Albrecht (1), the mature dry beans contain .212 per cent calcium, .600 per cent phosphorus, .0103 per cent iron, 1.910 per cent potassium, and .230 per cent magnesium. The biological availability of the abundant calcium and phosphorus is not well established, however, in the opinion of Barnes and Maack. (2)

Work done on the iron content indicates that it is biologically available. Yang and Dju (5) say that 88 per cent of the total iron is ionizable. Barnes and Maack (2) say that soybeans are an excellent source of thiamine, that they supply more niacin than do most vegetables and cereals, and that they are a fair source of vitamin E. They also say that the fresh green beans are a good source of vitamin A. Whiteman and Keyte (6) say that soybean sprouts are an excellent source of vitamin C and a fair source of calcium. They also say that soy flours are similar to the beans in food value.

Experimental work on soybeans and soy products was done at Michigan State College during World War II to test their acceptability in institution food service. (7)

All of the dishes were well accepted with the exception of those made with dry soybeans.

Dry Soybeans. Dry soybeans will probably never be very popular in the United States because they compete with dry navy, Lima and kidney beans, all of which are better liked. The large fat content makes them extremely oily which accounts, in part, for the distaste with which they are regarded.

SOAK BEANS OVERNIGHT

Dry soybeans should be soaked overnight and, contrary to the procedure recommended for other dry beans, the soaking water should be discarded and fresh water added for cooking. This will do away to some extent with the pronounced flavor which is objectionable to many. The beans can be boiled, steamed or cooked in a pressure cooker and used as they are, or they can be

baked following this preliminary cooking. They need long cooking to do away with their characteristic crunchiness. The time needed varies with the variety and some other factors.

Green Soybeans. Green soybeans are available fresh, only if they happen to be grown in the vicinity. Institutions that grow all or a part of their food might well add soybeans to the list of vegetables grown in order to have them in the fresh state. They are much better liked than are the dry beans. There are many vegetable varieties differing from each other in color, size and shape. It would be well to consult state agricultural colleges to ascertain what varieties will do well in a given area. Canned green soybeans are on the market; one of the large national grocery chains carries them regularly in its stores.

Soy Flour. This is the product that is, perhaps, best known inasmuch as muffin mixes, pancake mixes, and the flour itself have been sold in retail stores for some time. It is much used as a filler in bologna and other sausages instead of cereal. It is also used to a considerable extent in baked goods, its yellow color often lending the appearance of a larger egg content than is actually present. Prevention of staling in baked goods is one of its desirable effects.

CONTAINS LITTLE STARCH

Soy flour does not contain gluten, and its starch content is negligible. Consequently, it cannot be used as a complete substitute for wheat flour. It is more nearly comparable to dry powdered skim milk or dry powdered eggs. A 10 per cent substitution of soy flour for wheat flour in cakes and a 4 per cent substitution in breads can be made without any adjustment of the recipes. If larger substitutions are desired, special recipes should be used inasmuch as the quantities of other ingredients, especially the fat and the liquid, will be necessary.

In the experimental study at Michigan State College, cookies, muffins, coffee cake and cakes were successfully made substituting soy flour for wheat flour in proportions ranging from 24 to 100 per cent. Brownies were satisfactory with a 100 per cent substitution; plain cake, with 24 per cent, and chocolate cake, with 30 per cent. A 50 per cent substitution was made in an eggless spice cake with no detriment to flavor or texture. However, in soy cakes the volume is somewhat reduced. Soy flour was successfully used in pie crust also, when made in small quantities.

White sauces were not successful when made with soy flour. However, a chocolate sauce made with soy flour and soy milk was successful. Chocolate is a good masking agent and covers up any undesirable flavors in both soy flour and soy milk. Other strong flavors such as caramel might, presumably, have a similar effect.

Soy Grits. Grits vary in size, shape and color, depending upon the manufacturer, but all resemble bits of cereal or nutmeats. They, as well as the flour, were used for some of the numerous meat-extender mixes on the market during the war. Accordingly, the grits were tested in the study in the making of meat loaf and ham loaf.

A number of the judges thought that they gave a superior texture to these loaves and there was no detectable difference in flavor. In the ham loaf, the proportion of grits liked best was 1:5, yielding 7 servings per pound of meat. In the meat loaf, the proportion was 1:2.5, yielding 9.6 servings per pound of meat. The grits not only serve as a volume substitute for part of the meat, but actually provide additional protein and materially reduce the cost.

Grits may be added in any desired amount to cookies, muffins, coffee cake, yeast bread, and rolls. They resemble chopped nutmeats when so used and could be used in conjunction with them.

Soy Butter. Soy butter was available when the study was made and was substituted in cake making for the high ratio fat ordinarily used. A considerable amount of adjustment in the fat and liquid was necessary before an acceptable cake resulted. A 26.6 per cent increase in the fat and a 16.6 per cent reduction of the liquid in the standard recipe were necessary to produce a desirable cake. This resulted in an expensive product which was not the equal of cakes made with high-ratio hydrogenated fats. It would seem that a better use of the abundant fat in the soybean is its utilization in salad oil.

Soy Milk. Soy milk resembles cows' milk in appearance and consistency. Its composition varies with method of manufacture, composition of the beans, and the degree of concentration. It can be made from the whole bean or from soy flour. It can be bought dried or canned from commercial sources, or it can be "home-made."

The dried soy milk used in this study had a less pronounced beany flavor than did the canned milk used, but that may not be true of all of the dried soy milks available.

The milk was used in white sauces and vanilla and butterscotch sauces. None of these sauces was liked because the beany flavor was noticeable. Chocolate sauces were successful. Cream soups were not tested. Strongly flavored cream soups, such as onion, might be acceptable. Soy milks were successfully substituted for cows' milk in cakes. There was no appreciable change in appearance or flavor of the cakes.

Soy Sprouts. The bean sprout ordinarily served in Chinese restaurants is made from the mung bean which is not a soybean variety. Soybeans can be sprouted successfully, however, although it must be admitted that many prefer the mung bean because it has a longer sprout and the bean itself is very small.

EIGHT VARIETIES STUDIED

In this study, eight varieties of soybeans were sprouted: Chief, Illini, Richland, Manchu, Mandarin, Mingo, Bansei and Ebony. All sprouted well and the experimenters liked all of them, although some of the people to whom they were served expressed a preference for Ebony, a black skinned variety. Slipping the skins off would be a long, tedious process, prohibitive in labor cost. The skins are not objectionable in respect to palatability or appearance, however, and should not prove a deterrent to the use of this variety.

Institutions may sprout their own beans if desired. For a small quantity, No. 10 cans with holes punched in the bottom can be used. For a larger quantity, a home-made sprouting chamber such as that recommended by Beeskow (8) can be used. For 100-portion lots, McCay (9) suggests a 20-gallon galvanized can with an open top and a hole cut in the bottom for drainage. A cover for the bean sprouting vessel must be used as light must be excluded.

Soybean sprouts may be used as a vegetable alone or in combination with celery or onions or both. An excellent dish results when soy sprouts and mushrooms are added to sautéed onions. The sprouts can be chilled after boiling for a few minutes and then used in salads. They can be added to scrambled eggs or omelets, to stews and casserole dishes, or they can be used in the traditional way in chop suey or other Chinese dishes.

There are other soy products avail-

able besides the ones tested in this study. Soybean oil is perhaps the most important one yet to be investigated. However, since it can be used just as any cooking or salad oil, it presents no particular problems. The National Restaurant Association *Newsletter* for Sept. 9, 1943, contained a list compiled from United States Department of Agriculture sources of thirty-six commercial soy products.

Recipes in pamphlet form for the quantity use of soybeans and soy products can be obtained from most of the processors and manufacturers of such products. There are also a few books devoted to soy recipes, notably one with an intriguing title, "Soybeans From Soup to Nuts." (10) This book is intended for the housewife, but with a few exceptions the recipes can easily be enlarged to institution size.

Many an institution is interested in inexpensive protein dishes for budgetary reasons. Inasmuch as soybeans and their many products not only provide such a source but augment the mineral and vitamin content of the diet as well, it would seem that even though there is no longer a wartime accent on their use, they merit continued utilization.

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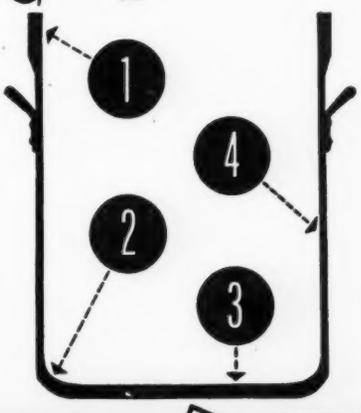

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FOOD FOR THOUGHT

Purchasing a Pressure Pan

All pressure pan manufacturers use materials and construction strong enough to prevent explosion. All cookers have some safety device to release dangerously high pressure—either a rubber diaphragm which blows out, or a metal plug which melts. Look for the seal of approval of the Underwriters' Laboratories, Inc.

Some cookers have controls which automatically hold the pressure at a point set, regardless of how high the heat is under the pan. Others have indicating gauges which show where the pressure is. In using these, heat must be adjusted to hold the desired pressure.

Cookers with flexible lids that snap in under the rim of the pan cannot be opened until the pressure is down, thus protecting the careless cook who tries to open the pan too soon. These flexible lids, however, dip down into the pan in opening and closing. Some other cookers have devices which keep the lid closed until there is no pressure inside.

To prevent burned hands, knobs and handles should be of a material and shape to handle comfortably when the pan is hot. Wood is heat resistant but has the disadvantage of charring or cracking when overheated. Heat-resistant plastic is being used for handles of some cookers.

The simpler and easier the cooker is to use and handle, the more convenient it is; the fewer the parts, the less to get out of order. Try putting on lids and sealing cookers before you buy, the specialists advise. Some lids close by sliding onto the pan; others fit inside the pan and seal against the rim.

Also try lifting the pan to be sure it will be comfortable to handle when filled with food. If the cooker has a gauge it should be easy to read as it stands on the stove. Notice whether the edge of the pan is straight and smooth for convenient pouring. Notice also whether the top curves so much that it will be difficult to stir or scrape out food.

Every part of the cooker should be easy to keep clean. A smooth surface, both inside and out, is easier to clean than is a rough surface. A removable rubber gasket is easier to keep clean than is one which fastens underneath an edge where it is difficult to reach. Handles and outside attachments that are smoothly fitted onto the pan offer fewer places for dirt to collect than do those with protruding bolts and screws.

Pressure saucepans, because of their price, are rightly considered long-time investments and should stand up over the years with ordinary use and care. Notice the rim of the pan especially to be sure it is sturdy enough not to dent and thus spoil the seal. Removable parts should be simple and require no special care to keep in order.

Choose a size that will hold the quantity of food needed. Several sizes are on the market. A new six-quart size for holding half hams, whole birds or large pot roasts is now available.

If a cooker is wanted for both cooking and canning, be sure its gauge or control is marked so that it can be held at 10 pounds' pressure, and be sure the pan is large enough to hold the size jars to be used in canning.

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Menus for August 1948

Susannah Bedell
Webber Hospital
Biddeford, Me.

1
Grapefruit Juice
Bacon and Eggs
•
Jellied Consommé
Broiled Steak
Mashed Potatoes,
Pan Gravy
Asparagus
Orange and Onion Salad
Vanilla Ice Cream
•
Chicken Noodle Soup
Brown Bread and Cheese
Sandwiches
Potato Chips
Sliced Tomatoes
Floating Island

2
Prunes
Scrambled Eggs
•
Breaded Pork Chops
Riced Potatoes, Gravy
Buttered Spinach
Combination Fruit Salad
Tapioca Cream
•
Tomato Soup
Cold Meats
Macaroni Salad
Celery and Carrot Sticks
Pears
Cookies

3
Tomato Juice
French Toast, Sirup
•
Chicken and Gravy on
Baking Powder Biscuits
Baked Potatoes
Peas and Carrots
Lime Gelatin Salad
Canned Peaches
Cookies
•
Mushroom Soup
Grilled Tomatoes and
Liver Patties
Banana Salad
Lemon Sponge, Custard
Sauce

4
Fresh Peaches
Poached Eggs
•
Meat Pinwheels,
Cheese Sauce
Boiled Potatoes
Green Peas
Apple and Nut Salad
Chocolate Pudding
•
Vegetable Soup
Chop Suey on Chinese
Noodles
Tossed Salad
Plums
Cookies

5
Stewed Apricots
Ham Omelet
•
Julienne Soup
Baked Rice and Cheese
Buttered Beets
Stuffed Olive and
Lettuce Salad
Nut Bread
Date Pudding,
Lemon Sauce
•
Hamburger Patties
Mashed Potatoes
Wax Beans
Lettuce, French Dressing
Applesauce
Cookies

6
Half Grapefruit
Scrambled Eggs
•
Noodle Soup
Baked Halibut,
Lemon Slices
Franconia Potatoes
Broccoli
Fruit Gelatin on Lettuce
Coffee Ice Cream
•
Clam Chowder
Escalloped Tomatoes
Stuffed Baked Potatoes
With Cheese
Waldorf Salad
Sliced Bananas, Cream

7
Cantaloupe
Soft Boiled Eggs
•
Baked Ham
Candied Sweets
Frozen Peas
Grapefruit and
Grape Salad
Rice Custard
•
Pea Soup
Cold Meats
Deviled Eggs
Potato Salad
Coleslaw
Brownies

8
Strawberries and Cream
Bacon and Toast
•
Consommé
Roast Capon
Mashed Potatoes, Gravy
Butternut Squash
Frozen Fruit Salad
Metropolitan Ice Cream
•
Scotch Broth
Creamed Asparagus
on Toast
Sliced Tomatoes
Pickles, Jelly
Fig Squares

9
Orange Juice
Poached Eggs
•
Vegetable Plate: Baked
Potato, Green Beans,
Carrots, Peas, Beets
White Grape Salad
Butterscotch Pudding
With Cream
•
Chicken Bouillon
Chop Suey on Rice
Cabbage Slaw
Apricot and Marshmallow
Tart

10
Half Grapefruit
Wheat Cakes, Sirup
•
Liver and Bacon
Stuffed Baked Potatoes
Summer Squash
Corn on Cob
Dutch Apple Cake
•
Cream of Mushroom Soup
Meat Loaf
Escalloped Potatoes
Tossed Salad
Gingerbread,
Whipped Cream

11
Baked Pears
Codfish Balls
•
Roast Leg of Lamb,
Mint Jelly
Parsley Potatoes
Asparagus Tips
Orange Salad
Maple Mousse
•
Cream of Tomato Soup
Cheese Soufflé
Baked Potatoes
Vegetable Salad
Chocolate Sundae

12
Tomato Juice
Coffee Cake
•
Cream of Corn Soup
Baked Hash
Spinach With Egg
Coconut, Celery and
Apple Salad
Meringue With Fruit,
Whipped Cream
•
Creamed Salmon
Baked Potatoes
Pickles, Celery
Apricot and Banana Salad
Mock Cherry Pie

13
Pineapple Juice
Poached Eggs
•
Tomato Soup
Broiled Halibut,
Tartare Sauce
Creamed Potatoes
String Beans
Coleslaw
Devil's Food
•
Lobster Stew
Cheese Fondue
Garden Greens Salad
Peaches and Cream

14
Blended Juices
Apple Muffins
•
Corn Fritters
Baked Potatoes
Cauliflower
Green Beans
Fruit Salad
Raspberry Ice Cream
•
Italian Spaghetti
With Meat Sauce
Tossed Green Salad
Fruit Compote
Cup Cakes

15
Sliced Bananas
Baked Eggs
•
Chicken Pie
Mashed Potatoes
Green Peas
Creamed Onions
Head Lettuce, French
Dressing
Vanilla Ice Cream,
Strawberry Sauce
•
Cream of Mushroom Soup
Pineapple and Cottage
Cheese Salad
Potato Chips
Sliced Tomatoes
Graham Cracker Pudding

16
Half Grapefruit
Bacon and Eggs
•
Roast Veal
Boiled Potatoes, Gravy
Fresh Spinach
Tomato and Lettuce Salad
White Cake
•
Beef Tea
Stuffed Green Peppers
Hot Potato Salad
Baking Powder Biscuits
Canned Apricots
Cookies

17
Applesauce
French Toast, Sirup
•
Meat Loaf
Escalloped Potatoes
Carrots and Peas
Waldorf Salad
Peach and Raisin Pie
•
Cream of Onion Soup
Lima Beans in
Casserole
Hot Muffins
Grapefruit and Celery
Salad
Blueberry Pie

18
Stewed Apricots
Omelet
•
Lamb Chops
Parsley Potatoes
Green Peas
Celery Curls
Cantaloupe Salad
Rice and Apple Pudding
•
Washington Chowder
Welsh Rabbit on Toast
With Bacon
Tossed Salad
Fruit Dumpling

19
Orange Juice
Ham and Eggs
•
Fruit Cocktail
Meat Pie With Potatoes,
Carrots and Turnips
Pickles, Olives
Tomato and Cucumber
Salad
Prune Whip
•
Lima Bean Purée
Eggs With Tomatoes
on Toast
Carrot Gelatin Salad
New England Pandowdy

20
Applesauce
Poached Eggs
•
Salmon Loaf With
Creamed Peas
Mashed Potatoes
Apple and Celery
Salad
Banana Cream Pie
•
Tomato Soup
Eggs au Gratin
Mixed Vegetable Salad
Chocolate Pudding

21
Pineapple Juice
Wheat Cakes, Sirup
•
Roast Lamb, Mint Sauce
Browned Potatoes
Summer Squash
Apricot and Banana Salad
Lemon Cream Pie
•
Green Pea Soup
Creamed Chipped Beef
Boiled Potatoes
Green Salad Bowl
Chocolate Cake

22
Stewed Prunes
Eggs and Bacon
•
Tomato Juice Cocktail
Roast Pork
Browned Potatoes, Gravy
Applesauce
Spinach
Cucumber Jelly Salad
Sponge Cake With
Whipped Cream
•
Half Grapefruit
Tuna Salad
Potato Chips
Graham Gems
Floating Island

23
Sliced Bananas
Scrambled Eggs
•
Hamburger Steak,
Tomato Sauce
Potato Cakes
Creamed Cauliflower
Coleslaw
Fruit Gelatin, Custard
Sauce
•
Tomato Soup
Rice Croquettes With
Cheese Sauce
Green Peas
Baked Apple With
Raisins and Nuts

24
Grapefruit Juice
Eggs on Toast
•
Veal Cutlets
Creamed Potatoes
Eggplant
Watercress Salad
Apple Pie, Cheese
•
Cream of Corn Soup
Stuffed Baked Potatoes
Cheese, Pickle, Pea Salad
Drop Biscuits
Pineapple
Cookies

25
Sliced Oranges
Soft Boiled Eggs
•
Pot Roast in Tomato
Sauce
Potatoes
Buttered Peas
Brown Bread
Vegetable Salad
Fruit Gelatin With
Cream
•
Onion Soup
Frankfurters
Hot Potato Salad
Coleslaw
Baked Apple, Cream

26
Pineapple Juice
Ham and Eggs
•
Chicken à la King
on Toast
Mashed Potatoes
French String Beans
Fruit Salad
Coconut Cake
•
Consommé
Jellied Meat Loaf
Creamed Potatoes
Green Salad
Vanilla Ice Cream

27
Half Grapefruit
French Toast, Sirup
•
Fillet of Sole,
White Sauce
Parsley Potatoes
Harvard Beets
Cucumber Salad
Steamed Peach Pudding
•
Clam Chowder
Macaroni and Cheese
Tomato and Lettuce Salad
Cherry Pie

28
Tomato Juice
Scrambled Eggs
•
Pork Chops Baked
With Apples
Escalloped Potatoes
Boiled Cabbage
Grapefruit Salad
Brown Betty
•
Cream of Spinach Soup
Fricassee of Lamb
Rice
Broccoli
Carrot and Raisin Salad
Applesauce
Cookies

29
Apricot Sauce
Bacon and Eggs
•
Fruit Cocktail
Roast Chicken
Mashed Potatoes,
Giblet Gravy
Wax Beans
Asparagus Salad
Angel Food Cake
•
Vegetable Soup
Eggs à la King on Toast
Fruit Salad Bowl
Ice Box Cake

30
Orange Juice
Coffee Cake, Jelly
•
Roast Beef, Horseradish
Sauce
Browned Potatoes, Gravy
Creamed Onions
Banana and Nut Salad
Cherry Pudding
•
Chicken Soup
Italian Spaghetti
Green Salad
Pears
Chocolate Cookies

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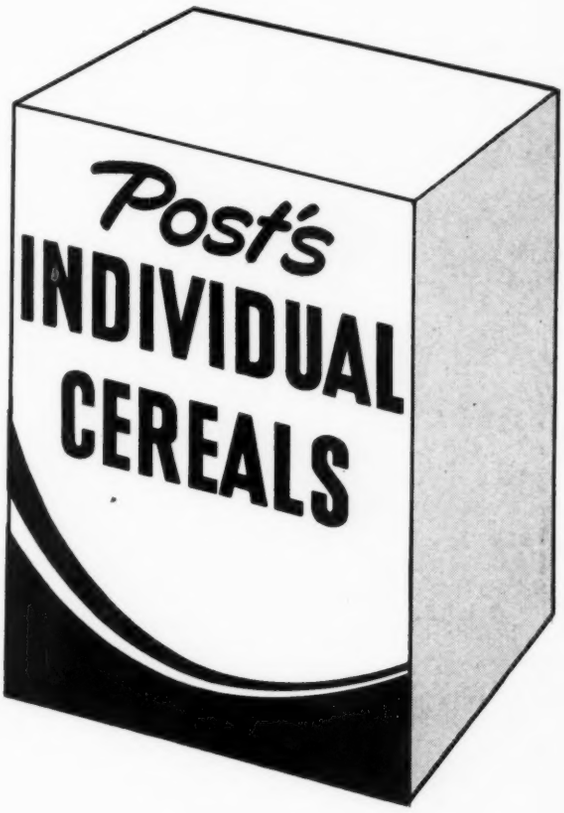

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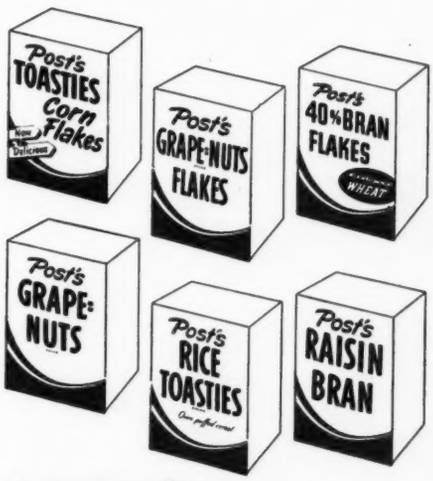

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POST'S *Individual* CEREALS

MAINTENANCE AND OPERATION

IRONING OUT THE WRINKLES IN THE LAUNDRY

This is the first of a series of three articles on renovation of a laundry

J. DON MILLER JR.
Assistant Administrator
St. Vincent's Hospital
Indianapolis

HOSPITAL laundries are often considered by administrators to be necessary annoyances in the operation of a well managed hospital. The work is not of a highly skilled or professional nature and the department is not a source of income. Yet a laundry can have a high nuisance value because of a sudden lack of cleanliness, damaged uniforms, or high replacement costs for linen. Like many services its value is realized more clearly when its work is interrupted and clean linen is not readily available.

A hospital laundry is unique in having several conditions, not present in other departments, which will allow good management to make this a model of operating economy and efficiency. It is possible by taking advantage of these factors to make the laundry one of the best managed departments in a hospital. A laundry has three conditions which make it a good laboratory for managerial efficiency. It has (1) a routine of washing and finishing with a minimum of variations; (2) all work concentrated in one area lending itself to close supervision, and (3) many repetitive operations which are adapted to labor saving machinery and methods. Many hospitals have taken advantage of these factors in some degree and consider their laundries to be one of the better managed departments. Yet after a study of the possibilities of the development of the factors enumerated, even these hospitals may find additional means of improving this service.

St. Vincent's Hospital, Indianapolis, has had a successful experience over the last two years which shows how much a good laundry service can contribute to the hospital. Our laundry had limped through the war years without a serious breakdown, but the hospital had grown used to a perpetual shortage of clean linen, slow deliveries from the laundry, and a quality of laundry service which left much to be desired. For a hospital of 340 beds and 60 bassinets there was a laundry occupying 3500 square feet of space, upstairs and downstairs, in a building separated from the hospital. There were two 42 by 72 inch washers, a smaller one, 33 by 30 inches, one 30 inch extractor, one six-roll flatwork ironer, two drying tumblers, two presses, and six hand ironing boards.

Among the twenty-six employes there was a nucleus of about eight people who were stable and had several years of service; the others had a fairly high turnover. None of the twenty-six employes had any assigned supervisory authority or responsibility; the laundry was managed on a part-time basis by the head of another department who was not skilled or experienced in laundry work. In the postwar plans of the hospital, reorganization of the laundry was one of the main objectives.

Our first move was to seek a person thoroughly skilled in laundry operations who could be put in complete charge. We wanted a competent person who would be given full cooperation from the administrator's office to reorganize this department. We were fortunate in finding a young man with more than ten years' experience in commercial laundries who had just been discharged from the army. He was employed as manager of the laundry and the central linen supply room and given complete responsibility for linen service to the hospital.

Beginning with this selection of an experienced laundry manager we have carried through a modernization program which has involved improvements in our laundering methods, equipment, personnel organization, and linen control. With the same number of people we are handling 25 per cent more poundage today than in 1946 and we are washing the linen for the hospital at a gross cost of slightly less than 5 cents per pound. The linen is whiter and is being delivered to all departments on schedule. Our laundry has proved to be a fortunate selection as a place to apply improved managerial technics. We have been able to take advantage of the three factors noted—established routines, close supervision and operations adapted to mechanization to improve our laundry. This process of renovation can best be understood by reference to four areas of management: methods, equipment, personnel and linen control.

METHODS

1. The key to a good laundry is a scientifically based washing formula which will ensure white and hygienically clean linen. This was the first item for investigation in our analysis of laundry methods. Up to this time the formulas for washing different linens were kept in the memory of the washman and were varied from time to time on the advice of salesmen, or as certain soaps or compounds were available. We did not have a standard washing formula. After a study of several combinations and making our own titrations we established a basic formula for all linen which involved a break or flush, two suds, four rinses, and was timed for a cycle of fifty minutes per load.

For a Bigger Laundry

in the Same 4 Walls

HOFFMAN EQUIPPED LAUNDRY at New York's Memorial Cancer Center Will Double Output to Match Expansion . . .

With the recent opening of the Sloan-Kettering Institute section of the Memorial Hospital Center for Cancer and Allied Diseases in New York, laundry requirements have increased materially. Eventually, twice the original number of beds and a proportionate increase in out-patient service are forseen, resulting in a need for doubling the original laundry output.

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Regular monthly meetings of the laundry personnel create an opportunity to discuss problems as they arise and to develop a spirit of group loyalty.

The manager arranged to have this basic formula printed on a board and placed on each washer in front of the washman. He also devised a peg board system to mark each step and thus he could check the progress of the washman through each washing cycle.

2. We varied this formula and the washing methods slightly to wash blankets, draperies and slip covers which formerly were dry cleaned. This effected a great saving in the expenses for outside cleaning service.

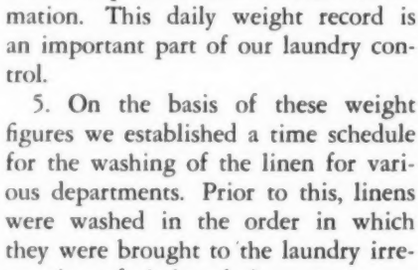
3. We changed the previous proportions of soap flakes and soap builder in our soap solution by decreasing the amount of soap and increasing the amount of alkali. We also used a commercial soap regenerator to stretch our soap supplies. These methods proved a great economy as the cost of soap has increased in the last two years.

4. Another basic innovation in our methods was to weigh all linen to provide accurate statistical information about the laundry operations. Up to this time there was no accounting or weighing of the work done. We had to adapt a grocer's platform scale to weigh laundry carts full of clean linen. The carpenter took the casters off an old scale, enlarged the platform and built a small ramp to carry the carts up and down from the scale. We began to keep daily records of the amount of work done in the laundry, broken down by classifications which suited our purpose.

We use these figures for a check on laundry operations, as a guide in ordering new machinery and equipment, as an aid in controlling supplies, as a basis for laundry cost analysis, and for numerous other problems which require accurate factual information. This daily weight record is an important part of our laundry control.

5. On the basis of these weight figures we established a time schedule for the washing of the linen for various departments. Prior to this, linens were washed in the order in which they were brought to the laundry irrespective of their relative urgency or importance. This caused many complaints of late deliveries of clean linen to all departments. There was no systematic order of production of clean linen. Now, for example, we wash surgery linen at 8:15 a.m. and 1 p.m. daily; obstetrical department items at 9 a.m.; wool blankets on Wednesday morning; draperies on Friday morning. All classes of linen are washed by a daily or weekly schedule which is geared to the activities of the whole hospital. Now it is only under unusual circumstances that a department complains about late delivery of clean linen.

A "walk-in" clothes chute permits the soiled linen to fall directly into the basket, thus saving extra handling of linen.



6. As an aid to this schedule of washing and in order to make our washing formulas most effective, we built sorting bins for a classification of linen before washing. By this method we separate the general hospital linen into three classifications: (1) sheets, (2) small flat work, and (3) tumble work (primarily toweling), and wash each group in a separate washer load. This enables us to vary the washing formula slightly, as the soil of the linen varies, and thus to produce cleaner linen. It simplifies the sorting at the shake-out table and now assures us of a full load for the tumblers or the flatwork ironer. Formerly a washer load of unsorted linen would have small amounts for each of these operations, hardly enough for a straight uninterrupted run on either finishing operation.

7. For a number of years the nursing school had sent out to a hand laundry the starched caps, collars and cuffs of student nurses for laundering. We shifted this operation to our laundry, put it under control for starching and for scheduled delivery and saved the additional expense.

8. For a long time there were complaints from numerous departments, including the surgery, that towels were not absorbent enough. This had been attributed in part to war-time fabrics. A study revealed that these towels and several similar items were being run through the flatwork ironer, thus pressing down the nap and making it nonabsorbent. We changed our method of finishing towels to drying them in a hot air tumbler. This fluffed up the nap, making the toweling more absorbent. It was an immediate solution to these complaints. It likewise speeded up the handling of these items and removed the pressure from an already overworked flatwork ironer. This also led us to find other items which could be better dried in the tumblers, and we soon found these

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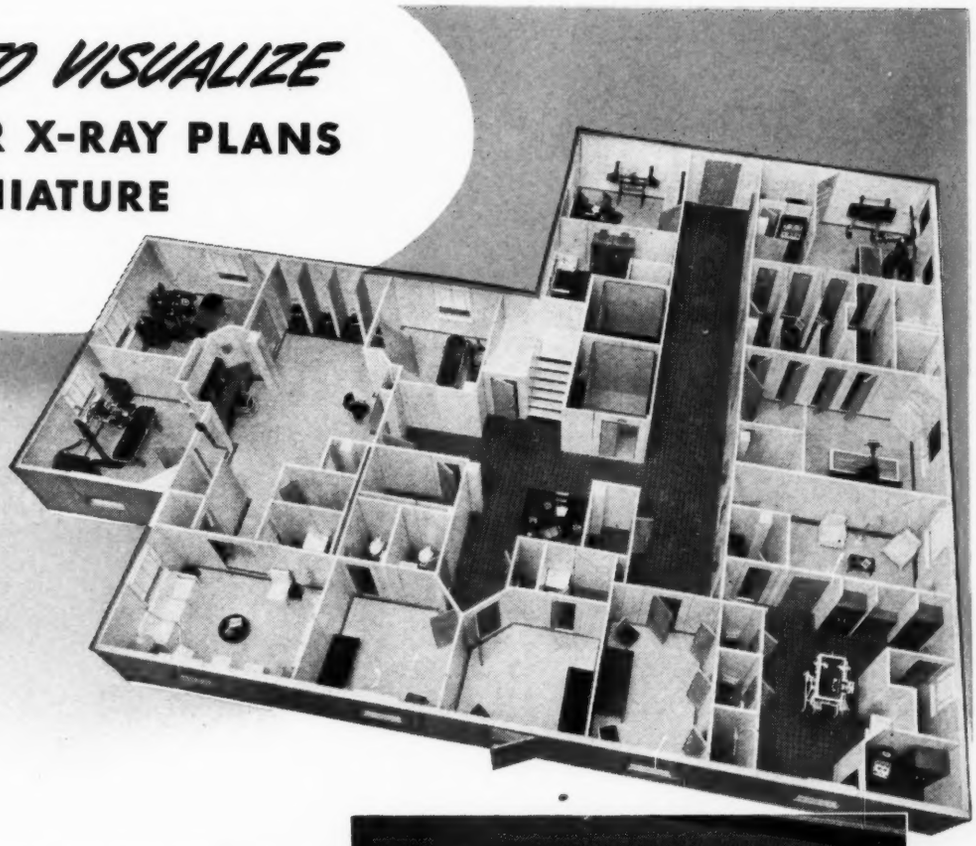

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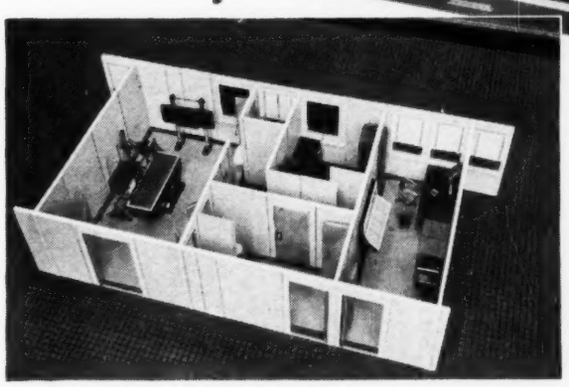

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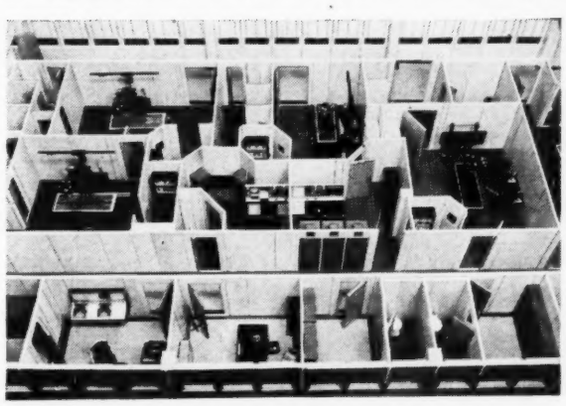

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machines working full time instead of part time as they had been.

9. From a commercial laundry our manager took an improved method of shaking out sheets and bedspreads preparatory to ironing. Formerly we used the familiar poles or bars over which sheets were hung. These bars were precariously set on stands, and there was a limit to the weight which each bar would carry without breaking. We threw out the bars and stands and substituted a flat table on which the sheets were spread folded once, lengthwise, with the top corners turned back for easy handling and feeding onto the ironer.

When we are ready to iron, the table is rolled up to the flatwork ironer and the sheets are fed directly onto the ironer tapes. The sheets can easily be fed continuously so that there is only a gap of about an inch between sheets. The former shake-out method created a larger gap between each sheet because of the difficulty in handling them. We thus are using our ironer more efficiently by having an almost continuous flow of sheets going through its rolls.

10. In operating the flatwork ironer we made an effort to use the whole width of the machine by assigning three people to feed linen. Even when sheets are being ironed there is enough room at one side to run small pieces. The ironer is running continuously and can finish work all along its entire width of 120 inches as easily as on a fraction of the width. We determined to use this machine to its maximum capacity and thus increased the amount of linen finished in eight hours.

11. We established the procedure of putting all uniforms of nurses and interns into nets to avoid rips and tears in these garments from handling. Prior to this we had complaints from time to time of sleeves badly torn and long rips in the uniforms. Nets give protection to the garment in the tumbling and throwing action of the washer and extractor.

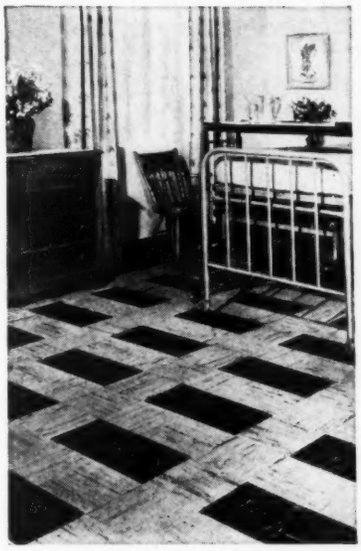
12. We laundered the uniforms for about seventy-five graduate nurses and interns each week. In order to keep an account of these garments we checked them in and out and thus avoided claims of lost uniforms. We also wrapped the clean uniforms in paper, and the business-like way of handling their personal laundry has created a good impression on these professional people.

13. As was the case in many hospital departments we were crowded for adequate working space. After analysis of our needs and the possibilities of rearranging space, we decided to move the tumblers upstairs from the first floor where the washers, extractors and ironer were located. This gave the tumbling operation more space and relieved the first floor congestion. The additional work involved in moving more laundry upstairs is more than compensated by the increased working area for all operations.

14. In order to maintain a straight line flow of linen from washers, through the extractors, and the flatwork ironer we turned the last machine around 90 degrees. This reduced confusion at the finish end of the ironer and now places the finish folding just at the delivery door where linen is ready to be sent to the linen room. It has eliminated the crossing of soiled linen and clean linen in the flow of work through the laundry.

15. We have two linen chutes in the hospital which had to be cleaned out by lifting the soiled linen from the pile on the floor into a truck. By

How to choose a better floor



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enlarging the cleanout doors to these chutes we have been able to put a truck into the chute and thus have the soiled linen fall into the truck. The truck is thus self-loaded which eliminates a job of loading by hand.

16. Housekeeping is a perpetual problem in a laundry and it can help or hinder the production of clean linen as it is done well or bad. In addition to continual insistence on good housekeeping during the day our manager devoted the last five minutes of every day to a clean up of the department. A regular assignment sheet and directed duties for each person were posted, and the manager became the inspector. This has contributed materially to a cleaner laundry, and the employes themselves have responded by their appreciation of a clean work area.

17. In his efforts to develop good managerial methods in the laundry the manager set up a budget for labor and supplies for the year. He was trying to set a standard to measure his own ability. In the first year he was able to keep within the limits of the budget every month except one.

18. Finally, as a way to check our laundering methods and to keep alert to improvements, we took a membership in the American Institute of Laundering. This gives us unbiased information about laundry methods and also provides a good reference and consultation service for our individual problems. Through the service we have solved some particular problems, such as removal of stains caused by x-ray film developer. We have found that it is well worth the membership fee to have this technical and professional service available.

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

COMBINING JOBS FOR BETTER SERVICE

DOROTHY I. ANDERSON

Dietitian-Housekeeper
Renton Hospital
Renton, Wash.

THE last decade has seen a sudden change in the evolution of hospitals. Our national economic policy has siphoned off much of the wealth which formerly was contributed to hospitals and other charities, and endowments no longer bring the return they did in former times. Hence, hospitals have had to look to new sources of income, and administrators have been forced to examine every means for practicing economies and increasing efficiency.

Besides the change in method of financing hospitals there has been a change in working conditions of employes—a social evolution if you please. To meet war-time conditions hospitals adopted the straight shift and the forty or forty-four hour week. Cash allowance for food replaced the provision of meals by the hospital. In many instances it is no longer necessary for employes to live at the hospital. These are all changes for the better, but they have increased hospital costs tremendously. All this, in addition to the fact that salaries and wages generally had to be raised in order to get workers, both professional and nonprofessional, has affected the administrator's attitude toward getting the greatest possible return from each employe.

This increased cost per worker has meant that he must be productive and efficient. He must be trained for the job and capable of performing it. In the past, many hospitals employed people more out of sympathy than with an eye to their actual usefulness. These persons were often placed in the dietary or housekeeping departments because it was considered that anyone could do this type of work.

In the small hospital the supervision of cleaning was often haphazard. Perhaps the superintendent assumed it in addition to her other duties. Perhaps some member of the nursing department was responsible. Often a worthy but untrained widow was put in charge. These people lacked training or time to give to the job and, as a result, unskilled help remained untrained and unsupervised. But with wages what they are in many hospitals today, employes must be carefully chosen, carefully trained, and continually supervised. This is the condition which brings the dietitian-housekeeper into the picture in the small hospital.

The advantages to the hospital are many. The dietitian is a trained executive. She can make and follow a budget. She understands inventory taking and its importance. She has had training in cleaning technics and job analysis. She is able to judge how a job can be done most efficiently and what materials should be used. She knows scheduling, job training, and personnel management. In these days of labor turnover, labor shortages, and higher costs these assets are invaluable in building an efficient, loyal staff for the hospital.

She has had training in the use of color and in interior decorating. She has studied textiles and knows how to choose and care for the sheets, towels, spreads, curtains and many other fabrics used by a hospital. In short, the dietitian brings to the hospital a background for scientific housekeeping.

Very small hospitals that feel they cannot afford a dietitian can often use a dietitian-housekeeper. The dietitian should increase the efficiency of these two departments, to say nothing of enhancing patient satisfaction and adequacy of the meals, which usually results when a dietitian takes over a dietary department that has previously been run by an untrained person.

A hospital which already has a dietitian can make better use of her training and abilities by putting her in charge of the two departments and giving her an assistant to care for some of the details if necessary. The increased responsibility should carry with it increased salary, which makes it pos-

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sible to keep a more experienced dietitian. At the same time the cost to the hospital is less than the salaries of a dietitian and an executive housekeeper.

There are advantages from the dietitian's standpoint also. As just mentioned, there is increased salary. Many dietitians like the friendly, family atmosphere of a small hospital but feel they must move on to a larger institution because of the increased financial return. To a person with an interest in administration, the challenge of two departments is just that much more satisfying. The diversification of jobs adds variety to the day.

Most dietitians in small hospitals spend one, two or more hours a day doing routine work which could just as well be done by someone trained for that specific work, but for which the five-year training of the dietitian is not necessary. Release from these less stimulating tasks and the taking on of more responsible work make the position more interesting and satisfying.

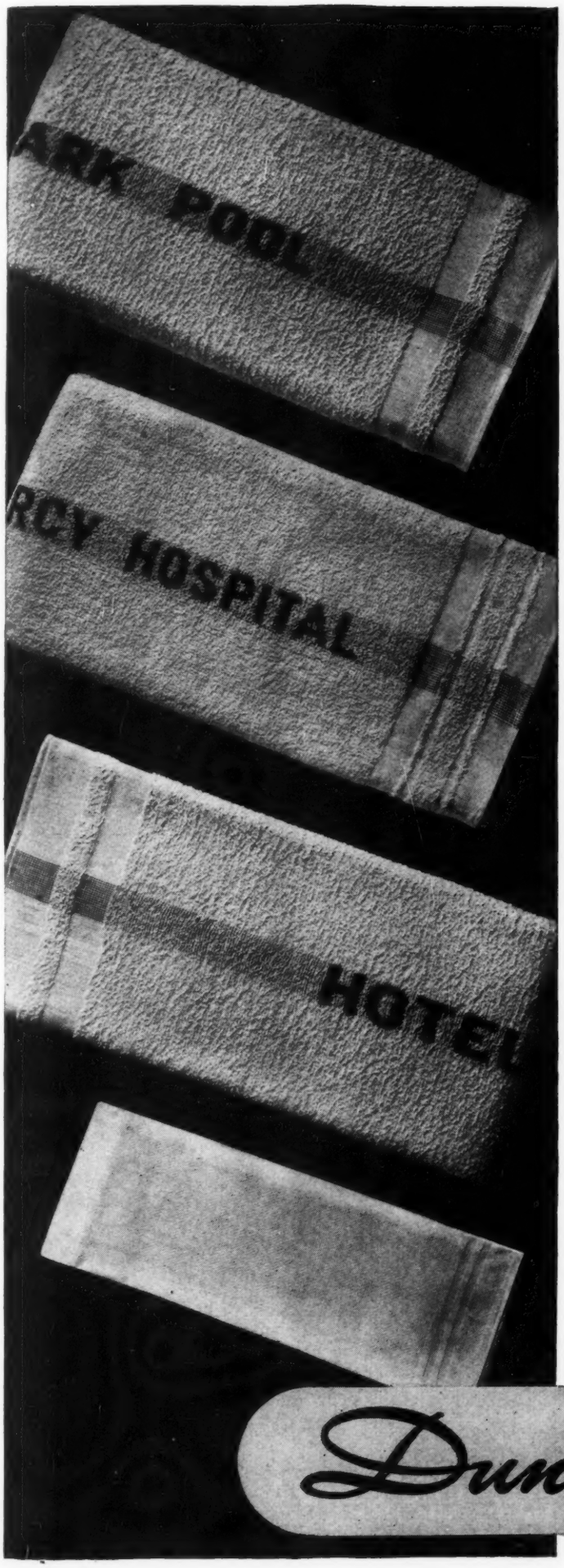
Some dietitians make infant formulas. This can be done equally well by a trained aide. An aide can telephone orders after they have been written by the dietitian. She can do all record keeping and compiling of reports. She can answer the telephone. She can tally selective menus and special diets and make the kitchen work sheets. The aide can check trays part of the time, although it is our belief that a dietitian should do it most of the time if standards are to be maintained at a high level. An aide instead of the dietitian can fill in when there is a help shortage. An aide or clerk can type menus and correspondence and duplicate selective menus.

At Renton Hospital, Renton, Wash., which has 100 adult beds and 30 bassinets, two dietitians working forty-four hours formerly covered the dietary department. They worked straight shifts except when one had a day off. At the time of the change when the head dietitian became dietitian-housekeeper, it was necessary to add only a dietitian aide to the staff. The head dietitian is responsible for the dietary department. She hires the employes, does the planning and purchasing and is responsible for all food service.

The assistant dietitian is directly responsible for scheduling employes' work, for supervision of food preparation and service and writing special diets. She takes the monthly inventory and supervises the aide in figuring food costs and checking invoices. The aide checks census and tray cards, weighs diabetic food and does innumerable small jobs to save the time of the dietitian. This aide also checks extensions of laundry bills and does other clerical work for the housekeeping department.

As housekeeper, the dietitian is responsible for the whole department. She hires, trains and supervises employes and is responsible for the cleanliness of the entire hospital and nurses' residence. The sewing room is also under her jurisdiction, and she is responsible for the making of new articles and the care and upkeep of old ones. Through semiannual inventories a check is kept on all linen. The hospital does not operate a laundry so the housekeeper is responsible for the checking of outgoing and incoming laundry. She also supervises the daily distribution of linen to the wards and all departments.

It is the feeling of both the administrator and the dietitans of this hospital that the combination of dietitian and housekeeper has been a desirable and advantageous arrangement from every point of view.



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CHRONIC DISEASE

Claude W. Munger, M.D.

(*Continued From Page* 82.)

ical care, and medical care in a clinic or physician's office. The existing hodgepodge of inadequate and unintegrated facilities and services for the care of chronic disease patients affords no indication of what the relative need for different forms of service would be in a community program planned from the standpoint of the actual needs of the patient and providing all resources required.

An attempt to make a rough estimate of the number of incapacitated chronically ill persons requiring medical and nursing care at the expense of the community in New York City led to the conclusion that 30 per cent need care in institutions, 30 per cent need care in their homes, and 40 per cent need medical attention in a clinic or physician's office, with variations of these percentages in different age groups.[6]

The same types of facility and service are in general required for all income groups, so that these figures are roughly indicative of the need for different types of provision for the whole community. A census of the chronically ill under the care of medical and social agencies in New York City indicated that about one-third of the chronically ill persons in the city were receiving some form of care from these agencies.

The number of persons who have the means to pay for their medical care in whole or in part is probably much larger than the number who need free service. The heavy expenses involved in chronic illness, however, eventually exhaust financial resources and force many persons into dependency. Moreover, chronic illness not only is an economic problem in itself but also creates many economic burdens that the community must eventually bear. Comparatively few families even among the comfortable middle-income group can meet the expense of a protracted chronic illness without going into debt or making unjustifiable inroads upon the standard of living of other members of the family.

[6]Jarrett, Mary C.: Memorandum on Social Security for the Chronically Ill. Committee on Chronic Illness, Welfare Council of New York City, 1938. Manuscript copy.

NEWS DIGEST

Plan 500-Bed Hospital at National Institute of Health . . . New York and Pennsylvania Join Middle Atlantic Group . . . Catholic Delegates Hear Hawley . . . Lamley Receives Award . . . Dr. Irons Heads A.M.A.

Plan 500-Bed Clinical Research Hospital at National Institute of Health

Dr. Jack Masur

WASHINGTON, D.C.—Plans for a 500-bed clinical research hospital to be constructed at the National Institute of Health at Bethesda, Md., were announced here last month by Oscar R. Ewing, Federal Security Administrator. Bids were invited in July for the first step of construction; it is expected that the project may be completed within three years after that date. Total cost of the project is estimated at $40,000,000. When completed, the hospital is expected to employ 2000 workers, Dr. Leonard Scheele, surgeon general of the U.S. Public Health Service, said.

Dr. Jack Masur has been appointed medical director of the center.

The thirteen-story brick building will house the National Institute of Mental Health and hospital facilities of the National Cancer Institute, the National Heart Institute and the National Institute of Dental Research; also services for studying patients with infectious and tropical diseases. Major emphasis will thus be placed on the predominant causes of death and the most frequent causes of disability in the nation today.

The unusual combination of hospital and laboratory facilities within a single structure will make possible a unified, planned attack by physicians and laboratory scientists upon some of medicine's most baffling problems, Mr. Ewing said. The hospital will have a capacity of 500 patients and will include the most modern facilities for providing patients with the highest quality of medical care.

Patients from all parts of the country will be referred to the clinical center by physicians, hospitals and other health agencies on the basis of problems under study at various times. Inasmuch as many of the patients will require an extensive period of hospitalization because of the long-term nature of the illnesses under treatment, the center will contain not only the usual features of a general hospital but also many special services. Medical and psychiatric social service, physical and occupational therapy, and rehabilitation services will be important adjuncts in the care of patients. To provide for the spiritual needs

Architect's drawing of N.I.H. hospital.

of patients there will be a chapel which will provide for religious services of all faiths.

Scientific laboratories will occupy two-thirds of the building, including the north side of the central structure and six wings. In one of the wings new products available through atomic energy research, and highly complex machines will be utilized for the treatment of certain forms of tumor and for the study of body functions in health and disease. In the planning and construction of the building the advice and guidance of many of the most prominent hospital experts, architects and scientists have been sought, Mr. Ewing stated.

The entire building will be air conditioned, and many areas will be acoustically treated. A two-corridor plan will permit close relationship between the clinical care and investigative areas, facilitating the team technic which has already produced notable medical discoveries. In the laboratories, a wide range of adaptability for changing needs will be afforded by demountable partitions and equipment, module construction, grouped service lines, outlets at regular intervals, and standardized laboratory benches.

N. Y., Pennsylvania Groups Vote for Participation in Middle Atlantic Conference

NEW YORK.—The New York and Pennsylvania hospital associations have voted favorably on participating in the Middle Atlantic Hospital Conference, which was previously approved by the New Jersey Hospital Association. Officers of the participating associations are conferring to set up the formal organization following favorable action by their memberships.

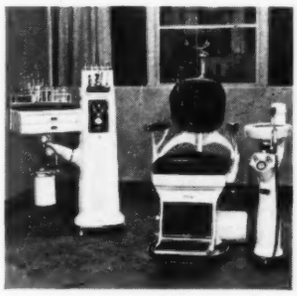
The conference will meet annually in Atlantic City, it was announced. A tentative reservation for May 18-20 has been made for the first such meeting to be held in 1949, according to John F. Worman, executive secretary of the Pennsylvania Association.

347 Federal Aid Applications

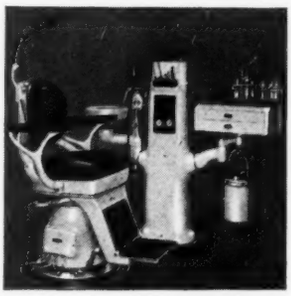
WASHINGTON, D.C.—The number of applications for federal aid approved under Public Law 725 reached 347 projects on June 25, the Division of Hospital Facilities, U.S. Public Health Service, announced. Estimated total cost of the projects is $160,463,523; of this amount the estimated federal share is $46,436,291.

Ritter Model MB Type 1 Unit for the physician who prefers to work with instruments and medicaments at right, Ritter Surgical Cuspidor at left of chair.

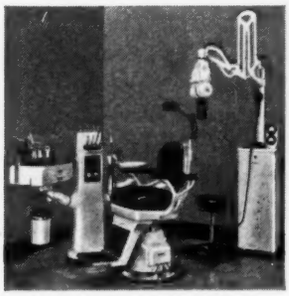
THERE ARE 4 Types OF Ritter ENT Units



Ritter MB Type 2 Unit at left with Surgical Cuspidor at right of chair.



Model MA Type 1 has swinging cuspidor, is positioned at the right of chair.



Model MA Type 2 also with swinging cuspidor but here Unit is placed at left of chair.

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Catholic Hospital Convention Speakers Urge Sound Business Management Practices

CLEVELAND. — Sisters operating the nation's Catholic hospitals were impressed with the importance of sound business management methods and urged to employ lay business managers at the twenty-third annual convention of the Catholic Hospital Association here last month. This advice was included in formal resolutions approved by the convention in its final session. In other resolutions the convention:

1. Praised the administration of Public Law 725 by the Hospital Facilities Division of the U.S. Public Health Service but added that larger appropriations would be needed to meet today's high construction costs and recommended extension of the law to cover a longer period.

2. Endorsed the objectives and program of the American College of Anesthesiology, thus reversing a trend among hospital groups, which have been flaying the college in recent months for overzealous publicity activity.

3. Urged its officers to review evaluation procedures used by professional approval authorities to determine how well these systems measure the quality of educational and professional service.

4. Called the attention of its members to the need for more psychiatric services in Catholic hospitals.

5. Acknowledged the need for better recognition of the general practitioner as a factor in medical service, and urged members to integrate practitioners in their hospital staff groups.

6. Recommended that hospitals take steps to explain high hospital charges to patients, church officials and public.

7. Emphasized the need for better personnel policies in hospitals.

During the convention, special honors were accorded to Rt. Rev. Msgr. Maurice F. Griffin, past president of the association, who was raised by the Pope to the position of a Prothonotary Apostolic, and to Ray Kneifl, executive secretary, who was given the rank of a Knight of St. Gregory.

The Sisters heard talks on various phases of hospital and health agency operation by many leading national authorities. Notable among these was an address by Dr. Paul R. Hawley, chief executive officer of the Blue Cross-Blue Shield commissions, who outlined the contrasting attitudes of a taxpayer and a contributor to a voluntary project.

The average taxpayer regards taxation "as a faintly disguised form of burglary and the government as a distant, cold and inhuman tyrant whom he is compelled to support," Dr. Hawley declared. "On the other hand, when a citizen contributes to a project voluntarily, he feels exalted because he has done an unselfish act and he has a personal and continuing interest in the project for which he feels a share of responsibility."

Catholic officers, left to right: Msgr. John J. Mulroy, Msgr. Maurice F. Griffin, Rev. George L. Smith, Rev. John Barrett.

Thus, we rob people of real spiritual values when we deprive them of the opportunity to support social welfare voluntarily, Dr. Hawley concluded.

Another outstanding feature of the convention was a description of the Saskatchewan compulsory health insurance plan by Dr. Leonard R. Rosenfeld who described the first year of operation of the plan as "successful to a degree" in making hospital services more readily available to the public. In a question and answer period following Dr. Rosenfeld's presentation, Rev. John W. Barrett of Chicago, new president-elect of the association, challenged the Canadian plan for not providing adequately for hospital expansion.

Rev. George Lewis Smith who took office as president of the association, outlined plans for regional institutes and other educational activities.

Approves Alberta Plan

CHICAGO.—Blue Cross approval has been granted to Associated Hospitals of Alberta by the board of trustees of the American Hospital Association, Richard M. Jones, director, Blue Cross Commission, announced. The newly approved plan provides Blue Cross hospital service benefits for residents of the Province of Alberta and maintains headquarters in Edmonton. Co-directors of the new plan, Joseph A. Monaghan and Harold D. Stacey, reported that enrollment began July 1.

Restore Eligibility for Federal Grants for Hospital Construction

WASHINGTON, D.C.—A bill restoring certain states to eligibility for receiving federal grants for hospital construction under the hospital survey and construction provisions of the Public Health Service Act became law with the President's signature June 19.

Under the former law, states which have not enacted legislation by July 1, 1948, requiring compliance with standards of maintenance and operation by hospitals receiving grants under Title VI of the Act were permanently barred from thereafter participating in the benefits of the hospital construction program.

The bill just made law will restore such states to eligibility upon enactment of such legislation. Under the amendment a state which enacts the necessary legislation after July 1, 1948, will be entitled so long as it complies with other requirements of the law to an allotment for the fiscal year in which such legislation is enacted and for the preceding fiscal year.

A.C.S. Names Saunders Associate Director

CHICAGO.—Dr. H. Prather Saunders has been appointed an associate director by the board of regents of the American College of Surgeons, Dr. Malcolm T. MacEachern, chairman of the administrative board, has announced.

Dr. Saunders joined the staff of the College in 1946 upon his return from active duty in the medical corps of the navy. He served in the navy for four years, during which time he spent twenty-one months in the Pacific as senior medical officer of a destroyer tender. He was president of the Chicago Medical Society in 1942 and secretary in 1939 and 1940. Dr. Saunders is a graduate of the University of Illinois College of Medicine.

N.L.R.B. Exempts Hospitals

WASHINGTON, D.C.—Nonprofit hospitals do not come under the National Labor Relations Board's ruling June 20 which requires an employer to bargain with representatives of his employes on any group health and accident insurance program covering them. The Taft-Hartley Act, P.L. 101, maintains that "employer" does not apply to nonprofit hospitals.

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Carl Lamley Receives Award as Outstanding Student in N.U. Administration Course

CHICAGO.—Carl C. Lamley, administrator of the Highland Park Hospital, Highland Park, Ill., received the Malcolm T. MacEachern Award as the outstanding student in Northwestern University's graduating class in hospital administration here last month.

Fifteen graduates received the master's degree in hospital administration and an additional six were given the bachelor's degree, bringing the total number of graduates of the Northwestern hospital program to fifty-five.

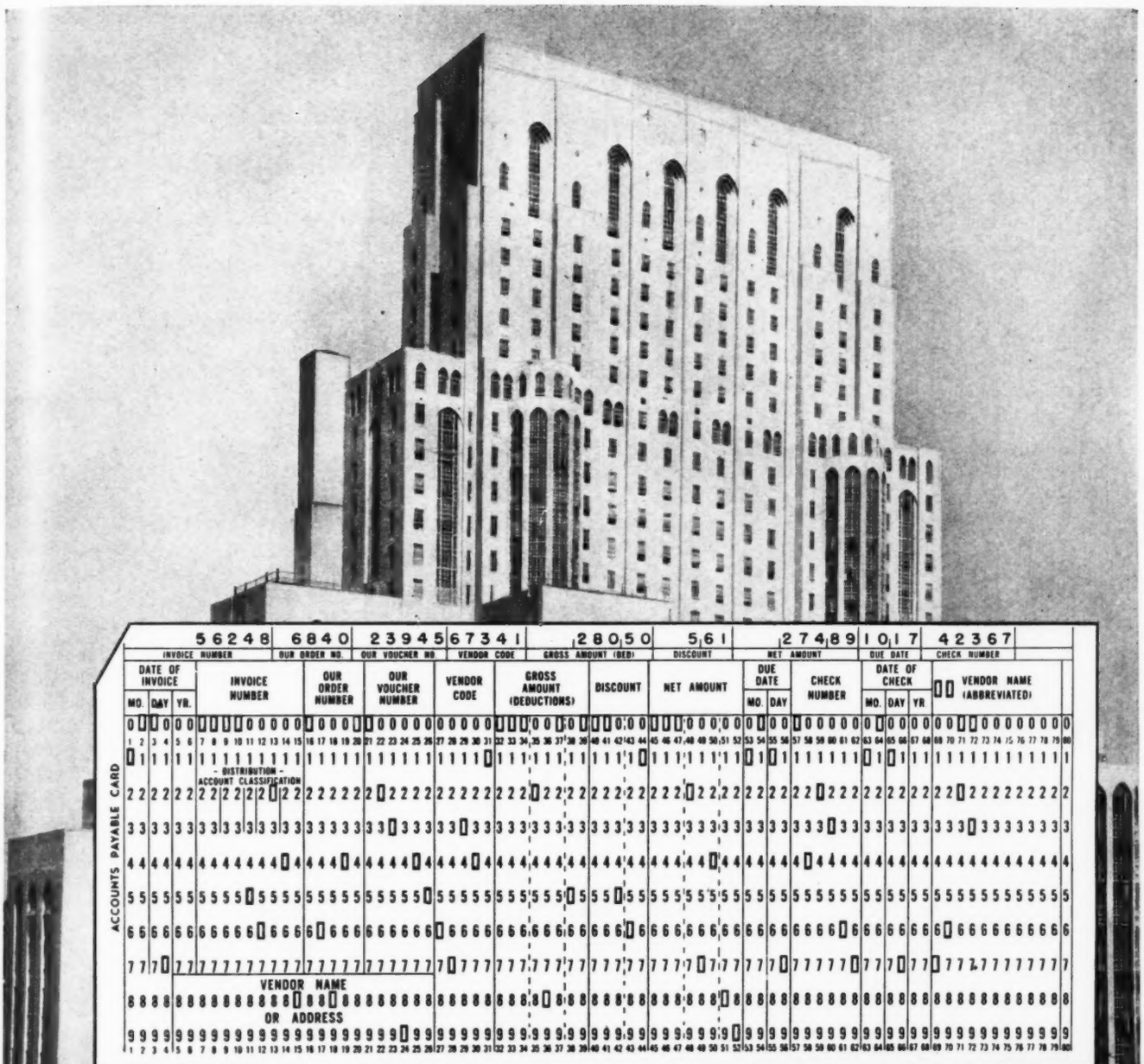
The MacEachern Award, which is sponsored by the Johnson and Johnson Research Foundation and includes a silver medal and $250 honorarium, is made annually to the student who completes the program "with the highest standing and who, in the judgment of the faculty, shows unusual promise of achievement in the profession of hospital administration," a university announcement said. Mr. Lamley completed his studies while serving as administrator of the Highland Park Hospital, Highland Park, Ill.

Marguerite M. Ducker, another member of the graduating class, received the Mary McGaw Award, established by Foster G. McGaw of Evanston in memory of his wife, for the graduate with the highest scholastic standing.

In addition to those previously announced, the following internship appointments for members of the graduating class have been made: Cleveland R. Chambliss, Freedmen's Hospital, Washington, D.C.; Sterling E. Gill, Freedmen's Hospital, Washington, D.C.; Alfred E. Henry, Indiana University Medical Center, Indianapolis; Joseph M. Henry, Council of Rochester Regional Hospitals, Inc., Rochester, N.Y., and Norman L. Thompson, Department of Mental Hygiene, State of California.

Music Therapy Experiment

NEW YORK.—The New York City Department of Hospitals has undertaken an experimental program of musical therapy in cooperation with the American Federation of Musicians, Dr. Edward M. Bernecker, hospital commissioner, announced here. The program will seek primarily to benefit children and adult psychiatric patients at Kings County Hospital by determining the comparative values of different forms of music in the handling of their problems.



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Ernest E. Irons Named President-Elect of A.M.A. at 101st Convention

CHICAGO.—Televised surgery broadcast from the operating rooms at Passavant Memorial Hospital and viewed on receiving screens at Navy Pier and several Chicago hospitals was the principal attraction as 12,000 doctors gathered here for the 101st annual convention of the American Medical Association. The broadcasts were sponsored jointly by the hospital, Northwestern University, R.C.A. and E. R. Squibb & Sons. The television clinics lasted throughout the week and were viewed at one time or another by most of the physicians attending the convention.

The televised operations were pronounced successful by Richard Vanderwarker, Passavant Hospital director, and Dr. J. Roscoe Miller, dean of the Northwestern medical school, and most observers commented that the operative fields and clinical demonstrations were clearly visible on the television screen. However, it was also remarked that operating room procedures were inconvenienced at times by the bulky television equipment and in the opinion of some the procedure offers no advantage in teaching compared to surgical moving pictures.

Dr. Ernest E. Irons, Chicago internist who has served the A.M.A. as secretary of the board of trustees for many years, was named president-elect of the association for the coming year. Dr. Irons charged physicians attending the convention with responsibility to carry on the fight against socialized medicine in their county medical societies. "American medicine has won a few of the preliminary skirmishes against forces that have been boring from within like termites to deprive medicine of its liberties," Dr. Irons declared. However, he added a warning that physicians should not become over confident because of these initial victories. "Other attacks are in the offing," he told the A.M.A. house of delegates. "We must arouse county medical societies to participation in the fight not only to preserve the freedom of medicine but also to preserve American democracy and the American way of life."

In its final meeting of the convention week, the A.M.A. house of delegates reportedly approved a resolution requesting association officers to "make every effort to obtain Blue Cross-Blue Shield coverage for headquarters personnel" at the expiration of the present insurance contract. This reverses the decision made early this year to cancel the A.M.A. employes' Blue Cross membership.

Hospital Charges Reach All-Time High, Report Shows

NEW YORK.—A special report on prevailing room and board charges in the seventy-six voluntary general and special hospitals in the New York area has been issued by the United Hospital Fund. A comparison of April 1948 rates with those reported in May 1947, together with a summary containing more detailed information, was included in the report.

Hospital charges have reached a new high, the report said. Two years ago (August 1946) most private rooms were priced between $9 and $12 per day, semiprivate rates were around $7 and $8, and ward rates ranged from $4.50 to $5 per day. According to the latest survey, current charges for private rooms now vary between $12 and $20 per day. Semiprivate rates range from $8 to $11, and the bed and board charges on general wards are between $6 and $8 per day.

U. S. Joins W.H.O.; First Assembly Sets Up Provisional Agenda

By EVA ADAMS CROSS

WASHINGTON, D.C. — The United States became an official member of the World Health Organization just in time for the World Health Assembly which opened in Geneva June 24. The legislation providing for membership and participation in W.H.O. became law June 14. The convening of the World Health Assembly marks the beginning of full-scale activity of W.H.O. and the termination of the interim phase of its development.

Congress authorized an annual appropriation of $1,920,000 for the payment by the United States of its share of the expenses of the organization; and such additional sums, not to exceed $83,000 for the fiscal year beginning July 1, 1947, for other expenses, including salaries for necessary personnel. The United States reserves the right to withdraw from the organization on one year's notice.

The President will designate not to exceed three delegates of the United States and a number of alternates to attend sessions of the World Health Assembly. One delegate will be designated as the chief delegate. Whenever the United States becomes entitled to name a person to serve on the executive board of the organization, the President will appoint a representative, by and with the advice of the Senate, and one alternate to attend sessions of the executive board.

Such representative must be a graduate of a recognized medical school and have spent not less than three years in active practice as a physician or surgeon. He will be paid $12,000 per year, the alternate, $10,000.

The first assembly was scheduled to inaugurate a program of international cooperation in the field of health. Excerpts from the provisional agenda cover international programs on malaria control, maternal and child health, tuberculosis, venereal diseases, and other activities covering general public health and certain health problems of considerable magnitude.

The Interim Commission recognized that W.H.O. will not be in a position in 1949 to develop full programs in all matters requiring international attention. It proposed to cover necessary initial activities to provide for the studies essential to further planning. The program adopted by this meeting will probably shape the World Health Organization for years to come.

Included in the recommended program for study are hospitals and clinics, medical care, medical rehabilitation, medical social work, nursing, public health administration, mental health, rural hygiene, tropical hygiene, nutrition, and numerous other subjects of international interest.

One of the most significant postwar developments in the organization of public health, according to an excerpt, has been the vast amount of reconstruction of the buildings and services of hospitals and clinics necessitated by destruction during the war.

As of June 19, Iceland and Hungary were the latest countries to file for membership. France ratified the constitution of W.H.O. on June 14. She is the 32nd U.N. member nation to approve the W.H.O. constitution.

$1000 for Asthma Study

WASHINGTON, D.C.—George Washington University Hospital has received a grant for $1000 for the hospitalization of patients suffering from intractable asthma, according to an announcement June 24. The grant was made by the Marcelle Fleischmann Foundation, Incorporated, of Baltimore.

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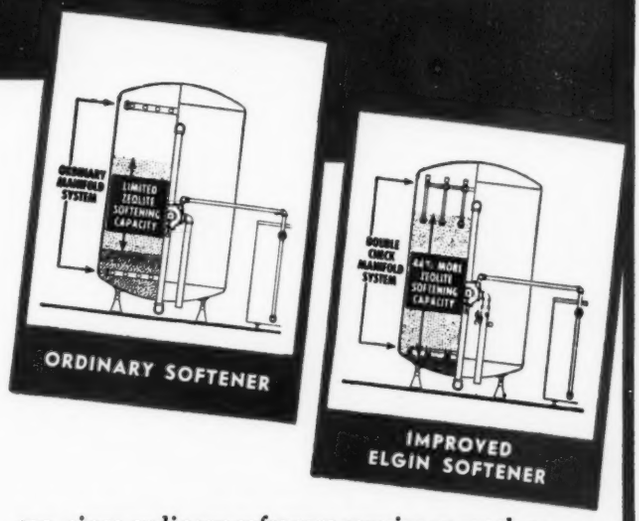

Prior to introduction of the improved Elgin, all zeolite water softeners were built basically like the ordinary unit here diagrammed. Note how the zeolite bed — the part that actually does the water softening — is comparatively shallow. This, in reality, was a compromise adopted as an attempt to limit the escape of zeolite during backwashing.

But now see how the present-day Elgin has changed the picture. By perfecting a new manifold system that prevents the escape of zeolite mechanically, Elgin has made it possible to utilize a far deeper zeolite bed. Coupled with the more efficient water distribution and zeolite regeneration made possible by this "Double-Check" Manifold, this deeper zeolite bed produces up to 44% more soft water output than can be delivered by an ordinary water softener of equal size. And this "Double-Check" principle is an Elgin development, fully protected by patents.

Obviously, in terms of soft water delivered, the Elgin way can reduce your original investment. It provides a more compact installation, too, since ordinary softeners require as much as 50% more space. And it keeps on saving over the years. The more thorough backwashing of the "Double-Check" system produces more zero-soft water per pound of salt, and keeps zeolite clean and active during a longer life. Prevention of zeolite loss means further economy.

Modernize old softeners, too

Your old softener, no matter what make, can be stepped up this new Elgin way. The "Double-Check" Manifold plus Elgin High Capacity Zeolite can mean as much as 44% more soft water output, at surprisingly low cost.

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Pilot Study on Child Health Reveals Meager Hospital Facilities

WASHINGTON, D.C.—The first detailed report at the state level on medical care of the nation's children, announced June 10 by the American Academy of Pediatricians, reveals, among other things, that there are relatively meager hospital facilities. The report covers a pilot study in North Carolina and includes findings in deficiencies in medical care for children and recommendations for the improvement of child health.

The report reveals in addition:

That each of the 1500 physicians in private practice in North Carolina averages three times as many children to attend as do physicians in more favored states.

Practically all the pediatricians are located in or near cities.

Only about 60 per cent of the general practitioners have received any appreciable hospital training in child care before entering practice.

Only about one-half the babies born during the year were born in hospitals.

Children in North Carolina receive, on the whole, 42 per cent less medical care than do those in the highest of other states.

Children living in isolated communities of the state receive 20 per cent less care than do those living in or near cities.

Nearly two-thirds of the state's ninety-nine counties are isolated, being predominantly rural. In these counties lives half of the state's 1,212,000 child population.

Recommendations of the North Carolina Committee stress the following:

The importance of more well trained physicians with inducements offered to attract these physicians to areas where they are needed.

Expansion of community health programs and hospital facilities.

Immediate development of programs for rheumatic fever and the care of prematurely born infants.

Creation of an advisory committee on child health, with representation and cooperative effort from agencies concerned with child health.

The pilot study in North Carolina was conducted by a committee under the chairmanship of Dr. Arthur H. London Jr. of Durham, with the cooperation of voluntary and official health agencies. Similar state reports by the academy's state chairmen are being prepared for other states. An overall national report will be issued next fall.

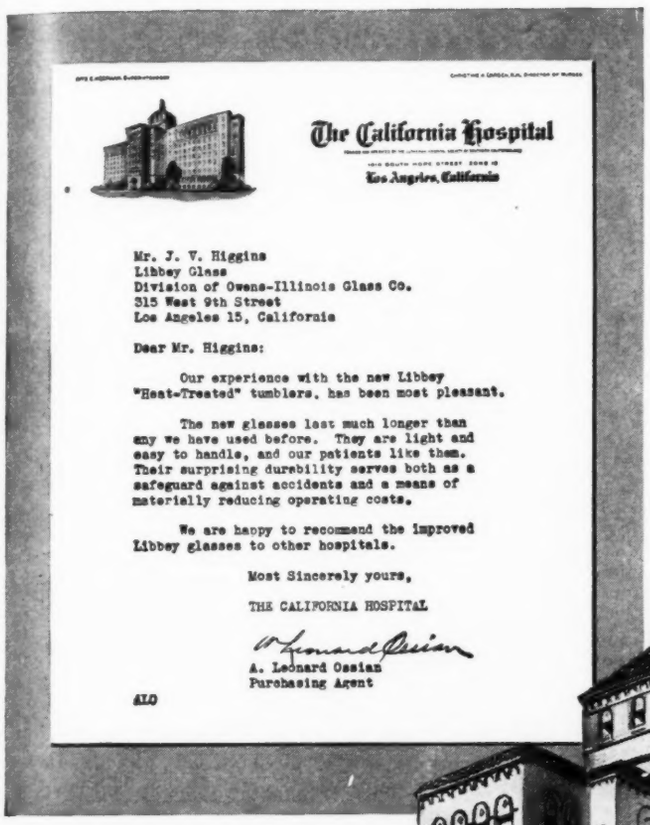
The academy's nationwide study covers every county in the United States at a cost of more than $1,000,000. It was conducted by a special committee of the academy under Dr. Warren R. Sisson of Boston, chairman, and Dr. John P. Hubbard, director, who was granted leave from the Harvard Medical School for the purpose. Active cooperation was given by the U.S. Public Health Service and the Childen's Bureau.

Reserve Officers Called

WASHINGTON, D.C.—Reserve officers of all sections of the Army Medical Department were called by Maj. Gen. Raymond W. Bliss, surgeon general, to undertake extended active duty tours. All service is on a voluntary basis. Some 1411 captains and lieutenants were required in June. More than half the requirement was in the army nurse corps where there were 820 vacancies. The medical service corps required 265 officers; medical corps, 203; women's medical service corps, 75; veterinary corps, 29, and dental corps, 19.

THE CALIFORNIA HOSPITAL REPORTS

LIBBEY HEAT-TREATED TUMBLERS . . .



The California Hospital
1414 SOUTH HOPE STREET ZONE 15
Los Angeles, California

Mr. J. V. Higgins
Libbey Glass
Division of Owens-Illinois Glass Co.
315 West 9th Street
Los Angeles 15, California

Dear Mr. Higgins:

Our experience with the new Libbey "Heat-Treated" tumblers, has been most pleasant.

The new glasses last much longer than any we have used before. They are light and easy to handle, and our patients like them. Their surprising durability serves both as a safeguard against accidents and a means of materially reducing operating costs.

We are happy to recommend the improved Libbey glasses to other hospitals.

Most Sincerely yours,

THE CALIFORNIA HOSPITAL

A. Leonard Ossian
Purchasing Agent

ALO

Safe-Economical!

REDUCE replacement costs . . . safeguard against accidents with Libbey Heat-Treated Tumblers. This is the advice of Mr. A. Leonard Ossian, Purchasing Agent at The California Hospital in Los Angeles, California.

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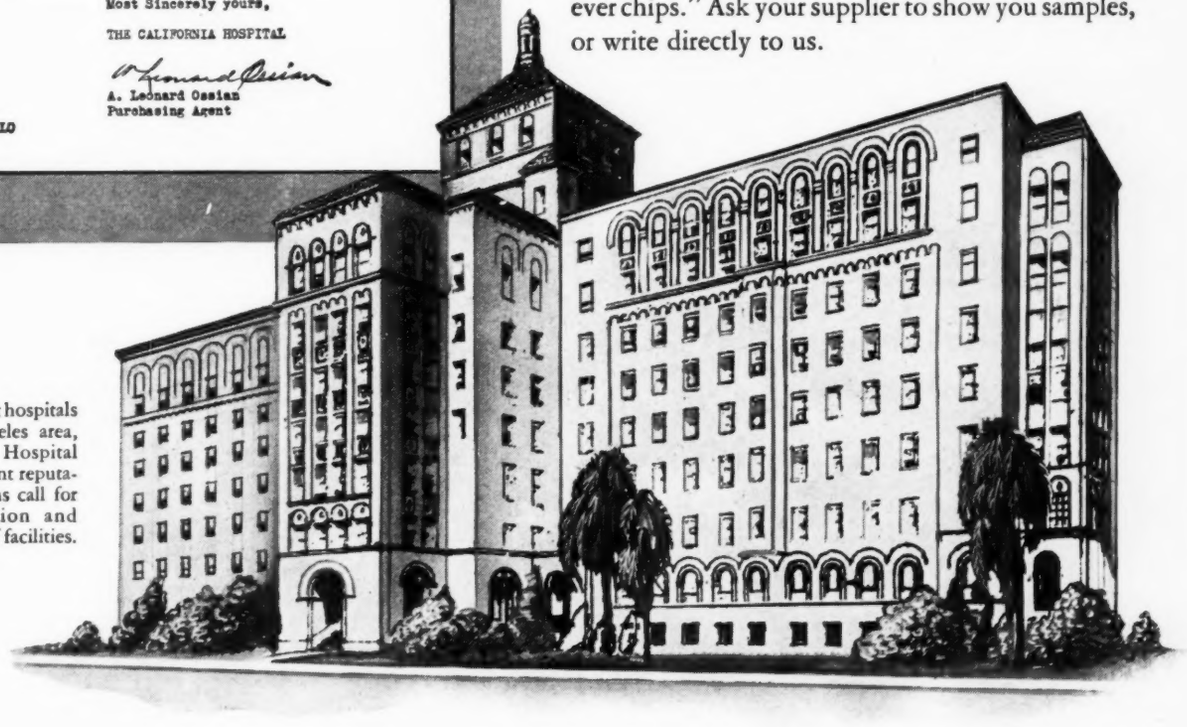
Every one of these famous tumblers is backed by the Libbey guarantee: "A new glass if the 'Safedge' ever chips." Ask your supplier to show you samples, or write directly to us.

One of the largest hospitals in the Los Angeles area, The California Hospital enjoys an excellent reputation. Future plans call for further expansion and modernization of facilities.



LIBBEY GLASS

Libbey HEAT-TREATED

Libbey Glass Company, Toledo 1, Ohio

Medical Journal Outlines Plan to Improve Finances of Washington Hospitals

WASHINGTON, D.C.—Only one of four separate groups of hospital patients has been carrying its full share of the hospitals' financial load, according to an editorial in *Medical Annals*, journal of the District of Columbia Medical Society. Patients who pay their own bills have been paying part of the bills of other patients, a journal editorial said, while those who have prepayment hospitalization insurance, patients supported by the Community Chest and tax-supported patients are contributing to hospital deficits.

Outlining a plan to put voluntary hospitals in the Washington district in better financial shape, the medical society called first of all for a reorganization of hospital business methods, including modern cost accounting systems. Collateral functions not essential to hospital service should be financed independently, the journal said. It recommended that hospitals withdraw from the community services program and hold their own fund raising drives. This last recommendation was criticized by the Washington *Star* which said in an editorial that "mass defection by the hospitals at this critical moment would be a severe blow to the United Community Services and might not cure the money troubles of hospitals."

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Elks Club, Los Angeles, Oct. 18-22. Extension Courses: Advanced Course, Duluth, Minn., Aug. 23-27. Regular Course, Los Angeles, Oct. 25-29.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 19, 20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Chicago Institute, University of Chicago, Sept. 7-17.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Statler, Washington, D.C., Sept. 7-11.

AMERICAN DIETETIC ASSOCIATION, Hotel Statler, Boston, Oct. 18-22.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 20-23.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Pennsylvania, New York City, Sept. 7-9.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Atlantic City, N.J., Sept. 17-19.

MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Statler Hotel, Washington, D. C., Nov. 8-9.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 17, 18.
1949

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, Ohio, March 23-26.

SOUTHEASTERN HOSPITAL CONFERENCE, Buena Vista Hotel, Biloxi, Miss., April 27-29.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, April 19-21.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis, May 26-28.

Kenosha Hospital Opens New Pediatric Department

KENOSHA, WIS.—A new pediatric department, widely publicized for its "dream murals" featuring familiar children's story characters, was opened here last month when the Kenosha Hospital inaugurated operation of a three-story forty-three-bed addition planned by Schmidt Garden & Erikson of Chicago. The addition increases hospital capacity to 179 beds, Omer Maphis, administrator, said.

Considerable publicity was given to the pediatric department which was described as "probably the most beautiful of its kind in the country." Walls of the pediatric corridors and rooms are finished in a permanent plastic material with a decorative design aimed at creating a favorable psychological environment for child patients.

Let Contracts for V.A. Hospital in Texas

WASHINGTON, D.C.—An estimated $4,750,000 was awarded in contracts in June for the construction of a 200 bed general medical and surgical hospital at Marlin, Tex.

The main hospital building will consist of space for 200 beds, modern clinical facilities for diagnosis and treatment, a chapel for religious services, a canteen and a recreation room. In addition to this main building, there will be quarters for members of the staff, nurses and attendants, and utility buildings.

Buildings for patients will be fireproof, with reinforced concrete frames and brick exterior walls backed up with hollow tile.

Scholarships Offered for Medical Students

TORONTO, ONT.—Scholarships amounting to $4500 have been made available for medical students in nine universities in Canada by Geoffrey H. Wood, president and general manager, G. H. Wood & Company, Toronto. The participating universities are the University of Toronto, McGill University, University of Montreal, University of New Brunswick, Dalhousie University, University of Saskatchewan, University of Manitoba, University of Alberta and the University of British Columbia. It is understood that other Canadian universities are to be included in future plans which the company's president has under consideration.

In the Better Hospitals the Silver is . . .

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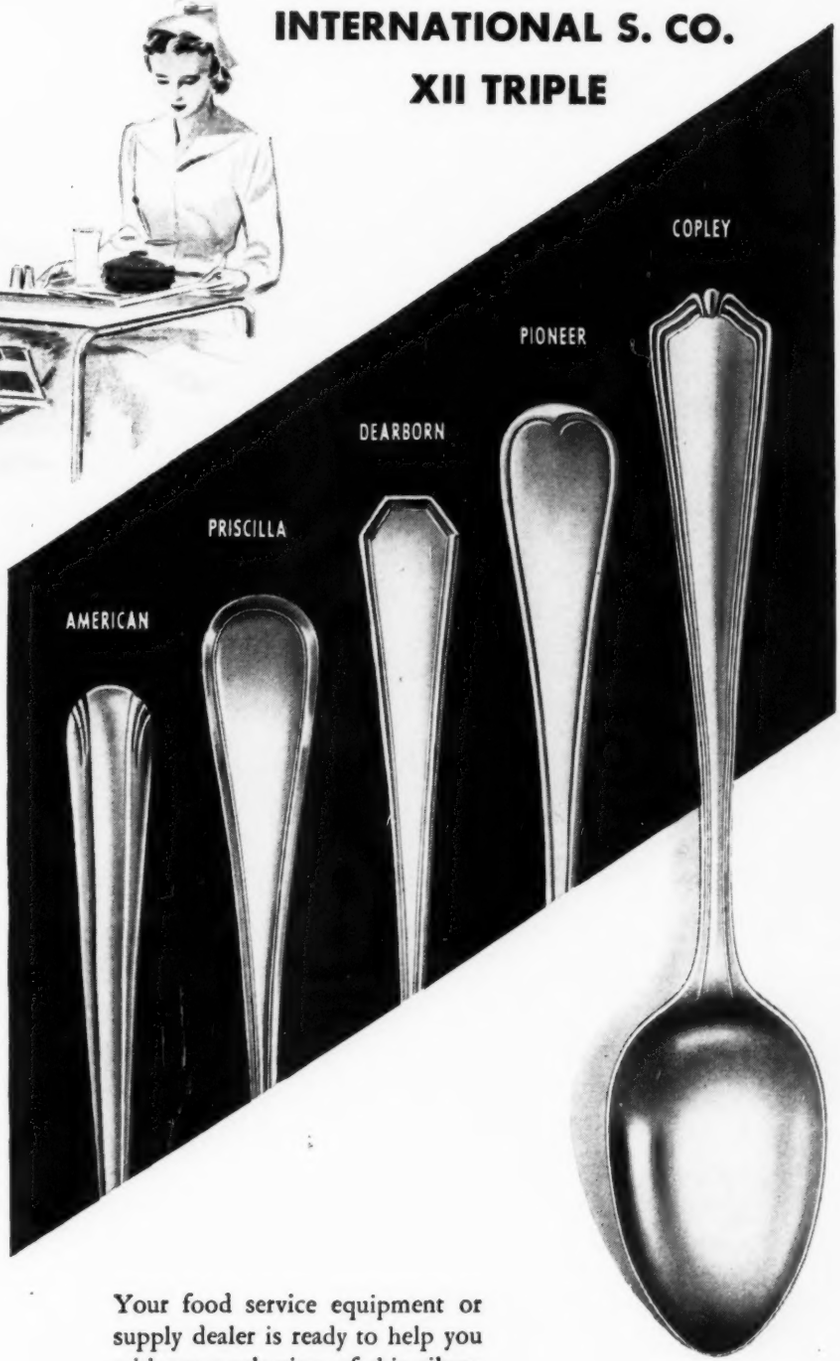

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1. A hard surface and uniform deposit of silver made possible by our modern plating methods.

2. Triple plating on heavy weight finely finished 18% nickel silver base metal.

3. Invisible overlay of pure silver on *back* of bowls and tines of staple pieces.

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5. A bright butler finish which adds richness to your tables.

6. Every item is heavier than you expect—to withstand extra hard use.

7. The base metal is carefully graded (distributed) for better balance and greater strength where needed most.

8. The practical Utility size fork with extra sturdy tines has many uses, assures uniform table setups.

9. New improved Cream Soup or Hotel size Bouillon Spoon.

10. Heavily silverplated Nickel Silver Hollow Handle Knives with several smart styles of Mirror Finish Blades of finest cutlery stainless steel. Blades will not loosen or break even after years in service.

Your food service equipment or supply dealer is ready to help you with your selection of this silverware. Ask him about International S. Co. XII Triple silverplate today.

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QUALITY SILVERWARE for **HOTELS • RESTAURANTS • HOSPITALS • TEAROOMS • CLUBS**

Government to Study Methods of Preventing Operating Room Explosions

By EVA ADAMS CROSS

WASHINGTON, D.C.—Initiating a scientific investigation into the causes of explosions in hospital operating rooms, the government on June 21 set up a nine-man committee to conduct the job. Equipment, interior finish, floors, ventilating systems, and even the clothing and shoes worn by those who enter the operating room will be studied from the standpoint of safety.

Named on the "Committee to Investigate Causes of Explosions in Operating Rooms" are seven experts from six federal agencies and two Public Buildings Administration officials. Findings will be made available to all government departments and to the management and builders of voluntary hospitals as a code to make operating rooms as safe from explosions as scientifically possible.

Tentative specifications will be made for operating room floors which will include the floor extending 15 feet outside of the operating room doors. The specifications will also embrace a testing device to check the resistance of the shoes worn by the occupants before they enter the room.

Subcommittees have been named to study each phase of the investigation: floors, ventilation, movable equipment, and the clothing of the occupants of the room. These committees will report to the full committee within a few months. Represented on the full committee are: the National Bureau of Standards; the Bureau of Mines; the Navy Department; the Corps of Engineers, U.S. Army; Public Buildings Administration; the U.S. Public Health Service, and the Veterans Administration. In a subcommittee, there will be an anesthetist and a physician.

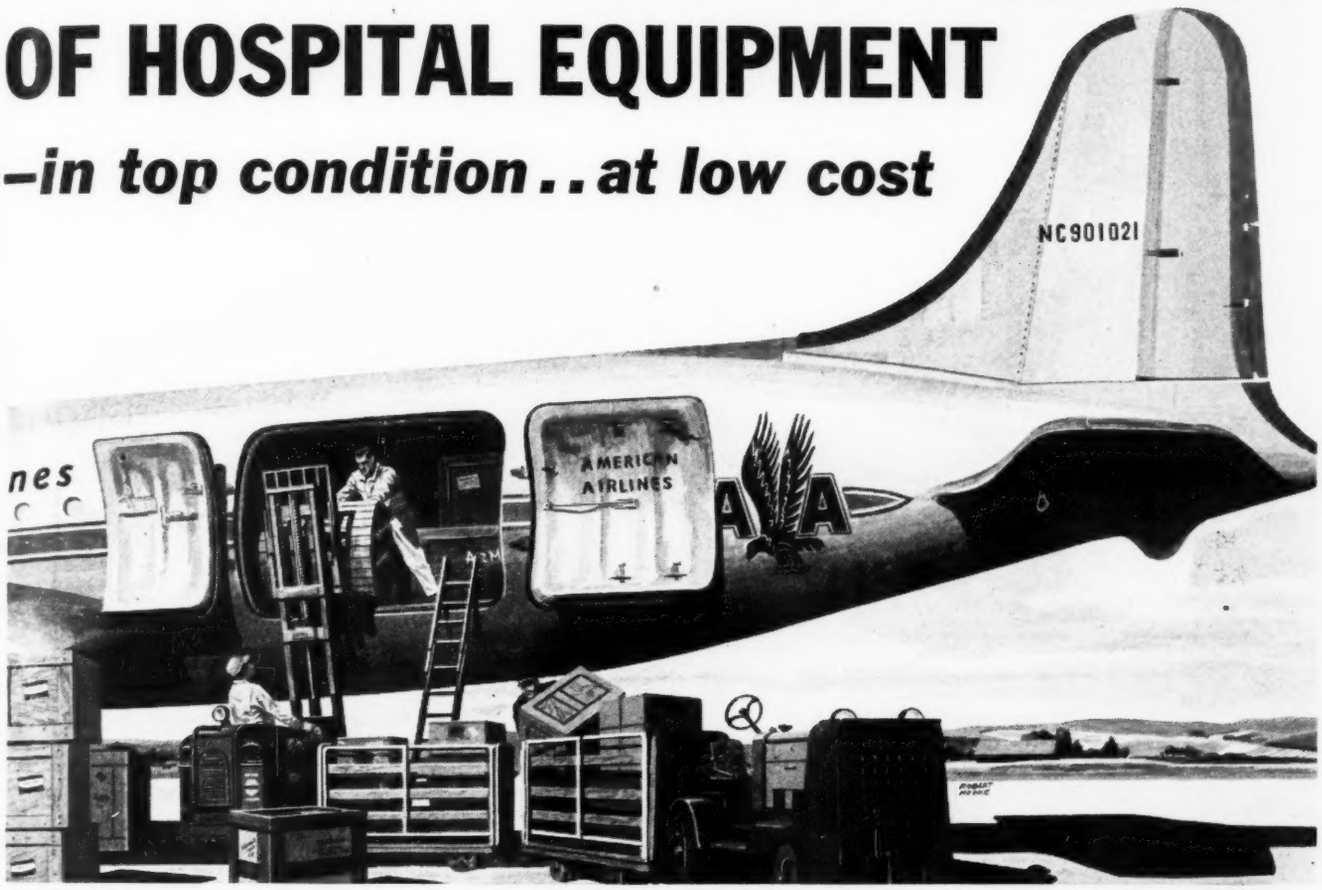
The report of the full committee, created by W. E. Reynolds, commissioner of P.B.A., will not only include the architectural and engineering features of an operating room but also present definite recommendations for those in charge of hospitals to guide them in the control of personnel and movable equipment.

Service Pins for Employes

NEW YORK—Fifty-five employes of St. Vincent's Hospital with service records ranging from ten to thirty-six years were decorated with sterling silver service pins by Sister Loretto Bernard, administrator, at a meeting in the nurses' auditorium of the hospital recently.

HOW TO GET NEXT-DAY DELIVERY OF HOSPITAL EQUIPMENT

—in top condition . . at low cost



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American's Airfreight is available to and from 69 airports serving thousands of communities — and American's cargo-carrying capacity is the world's largest. You'll get *quick* action with American — on regular schedule — to points near and far along American's far-flung Flagship routes. For details call your nearest American Airlines office or write to American Airlines, Inc., Cargo Division, 100 East 42nd Street, New York 17, New York.

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Save valuable man-hours and increase productiveness of all traveling personnel. Multiply personal contacts . . . give better service, build good will.

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GENTLEMEN: We would like to talk with your sales engineers and find out how your AIRCONOMY PLAN applies to our business.

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Budget Bureau Writes Finis to Federal Board of Hospitalization

By EVA ADAMS CROSS

WASHINGTON, D.C.—With the abruptness of "pink slips" and thirty days' notice to the office staff, the Bureau of the Budget wrote an end to the Federal Board of Hospitalization June 30. The board's general functions, the supervision of plans of the federal hospital system, will be taken over by the Budget Bureau which will henceforth call the shots in such matters.

The job of the Federal Board of Hospitalization, set up under Presidential directive, has been essentially completed, said B. Frank Bennett, staff director of the board in explaining its sudden dissolution. For some months past, members of the board have felt that with the completion of its current functions in regard to plans for new veterans', military and public health hospitals, the group should either close up shop or expand its activities.

The board recognizes, Mr. Bennett pointed out, that a big field remains which calls for exploration by some agency of the federal government. He referred specifically to a program, spearheaded by the government, leading to the development and procurement of more and better medical personnel—not only doctors, dentists and nurses but laboratory assistants and other technical personnel.

The Federal Board of Hospitalization has long been keenly aware of the need of closer integration with the nonfederal system of civilian hospitals, said Mr. Bennett. In locating V.A. hospitals, although the aim was to place big hospitals in metropolitan areas near medical centers, the board has spotted areas far removed from urban districts with small 100 or 200-bed hospitals designed ultimately to meet the needs of the community and to be absorbed by it.

The board was organized in 1921 for the purpose of coordinating the separate hospitalization activities of the army, the navy, the U.S. Public Health Service, the Veterans Administration, St. Elizabeths Hospital, and the Office of the Commissioner of Indian Affairs. In 1943, the board was designated as an advisory body to the Bureau of the Budget.

The board members were: the surgeons general of the army, navy and Public Health Service, the chief medical director of the Veterans Administration, the commissioner of Indian Affairs, the director of the Bureau of Prisons, and the director of the Bureau of the Budget who served as the board's chairman.

V.A. Inaugurates TB Follow-Up Program

WASHINGTON, D.C.—Veterans Administration has inaugurated a comprehensive follow-up program among the thousands of veterans suffering from tuberculosis, according to an announcement June 22. All of V.A.'s 126 hospitals and seventy regional offices are cooperating in the care of more than 13,000 veterans suffering from this disease.

Dr. John Barnwell, chief of tuberculosis service in the Department of Medicine and Surgery, said V.A.'s follow-up program is designed to discover relapses early among tuberculosis sufferers and to institute further treatment promptly. Each veteran patient, before he is discharged from the hospital, is fully advised what to do to assist in keeping the disease under control. Among other things, he is urged to report at regular intervals for x-ray examinations, fluoroscopic examinations, sputum tests, and other necessary checks or treatment.

"We are glad to recommend these products to others"

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Charlotte, N. C.

April 6, 1948

R. M. Hollingshead Corporation
Camden
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Gentlemen:

For the past ten years our cafeterias have been using several products manufactured by the R. M. Hollingshead Corporation. We operate eight cafeterias which serve approximately 12 million meals a year. It is highly important that we use products of high quality that will enable us to do an excellent job of maintenance.

We have found that Whiz products measure up to our requirements, with their quality always satisfactory and their price in line.

We are glad to recommend these products to others.

Yours very truly,

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E. T. Blair, PURCHASING AGENT

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AN ORGANIZATION SPECIALIZING EXCLUSIVELY IN THE PRODUCTION AND SERVING OF WHOLESOME FOODS

THAT STATEMENT SUMS UP THE HIGH REGARD OF S & W CAFETERIAS FOR WHIZ PRODUCTS! This famous chain of eight cafeterias, serving twelve million meals a year, cannot compromise with cleanliness. The letter signed by E. T. Blair, Purchasing Agent, tells the whole story—*it's a testimonial that really means something!*

This is the kind of approval that keeps coming in from Whiz users all over the country. "An excellent job of maintenance." "The best results with big savings in man-hours!" The words may differ, but, in effect, they all say the same thing: *Whiz does a better job in less time with less effort!* And time after time we are told that important *extra* savings come from using the *complete* Whiz line to eliminate expense, trouble, and time involved in scattered buying.

Ask your local Whiz distributor about the products that will help *you* do a better job at less cost. *R. M. Hollingshead Corporation, Camden, New Jersey; Toronto, Canada.*

The complete Whiz line includes:

floor cleaners and waxes; special cleaners; disinfectants; hand soaps and scrubbing soaps; metal and furniture polishes.

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Pasadena Hospitals Adopt Visiting Regulations in Maternity Departments

PASADENA, CALIF.—Huntington Memorial, St. Luke and Woman's hospitals here have adopted visiting regulations in maternity departments suggested by Pasadena's obstetricians and pediatricians as most conducive to the safety of mothers and infants, a hospital announcement stated. Under the new regulations, husbands will be the only visitors to the maternity departments of the three hospitals. They will be welcomed during the regular afternoon and evening visiting hours of 2 to 3:30 and 7 to 8, and also during the period when the wife is in labor and for a short visit after the birth of the baby.

Grandparents, sisters, cousins, aunts and friends will be asked to wait until the mother has returned home to pay their visits, the announcement said. Since most mothers are now going home on the fifth to the seventh day after delivery, they will have a better opportunity to regain their strength before receiving visitors.

Similar regulations have been in force on a temporary basis for the last six months and many mothers have indicated that they were able to obtain much more rest in the hospital than was true when visiting was unlimited, it was reported. Also the smaller amount of traffic in the rooms and corridors will, it is believed, reduce the likelihood of any form of contagion entering the maternity departments.

If the husband is unable to visit during the entire period of the hospital stay, one substitute visitor may be named by the wife for this entire period. Different substitutes cannot be named for different days, however. Husbands are asked not to visit if they have colds or any other illness that might be infectious.

Dr. Andrew G. DuMez Is Remington Medalist

WASHINGTON, D.C.—Dr. Andrew G. DuMez of Baltimore, secretary of the American Council on Pharmaceutical Education and dean of the University of Maryland School of Pharmacy, has been named the 26th Remington Medalist, according to an announcement of the American Pharmaceutical Association. The award is made by the New York branch of the A.Ph.A., and the 1948 presentation ceremonies will be made in New York City sometime this fall.

The gold medal commemorates Joseph P. Remington, universally known pharmacist, who was chairman of the U.S.P. Revision Committee for several decades and made many contributions to research, education and pharmaceutical literature. The honor is conferred upon the person whose work during the preceding year, or culminating over a period of years, is judged most important to American pharmacy by the committee, which consists of past presidents of the American Pharmaceutical Association.

Approve V.A. Internships

WASHINGTON, D.C.—The bill to establish internships in the Veterans Administration's department of medicine and surgery was passed by both Houses June 14. Intern service in veterans' hospitals will be similar to that found in first-class private, state, and county hospitals, and in federal institutions such as the army, navy and Public Health Service. It is anticipated that approximately 200 interns will be appointed during the first fiscal year.

Building Materials Are Available, Speaker Tells Catholic Exposition

CHICAGO.—Building material shortages and headaches on construction projects can be avoided entirely if owner, architect and contractor will collaborate in the selection of materials and plan construction so that orders may be placed several months ahead of actual need, George F. Hutter, a construction contractor, declared at the National Catholic Building Exposition here in July. Shortages of building materials are "just about things of the past," Mr. Hutter said, adding that the building picture looks encouraging because "the industry has recovered from wartime dislocation."

Mr. Hutter scoffed at rumors of new "miracle materials," adding, however, that construction in the future would be aided by prefabricated "packaged" kitchen, laundry and plumbing assemblies. Prefinished flooring, new insulating and acoustical materials, better paint and modular dimensions and more efficient heating systems will also help in future construction, he said.

In another address at the exposition, Samuel R. Lewis, former president of the American Society of Heating and Ventilating Engineers, said that radiant heating and other new methods "are pushing the familiar cast-iron free standing radiator right off the blue prints." Radiant heating "not only gives better heat at reduced fuel costs, but also does away with bulky radiators and the smudges of dirt they leave on walls and ceilings," Mr. Lewis said.

Homer Hoyt, city planning expert and author of a number of books on real estate planning, told the exposition that cities are "flattening out" into the surrounding countryside, leaving a residue of blighted sections whose dilapidated buildings are breeding places for crime and disease. Mr. Hoyt urged builders of Catholic institutions to keep abreast of shifting population movements and locate in new neighborhoods protected from disintegration.

A.M.A. Committee Stresses Importance of Blood Program

WASHINGTON, D.C. — The importance to the nation of a constant, dependable supply of blood and its derivatives was stressed by an American Medical Association committee in a report on the National Blood Program of the American Red Cross. Committee members said the program was "the best plan so far devised" to meet the country's needs.

The report emphasized that (1) no local program can or will be instituted by the Red Cross without the approval of the local medical societies, hospitals, and health department officials, and (2) that in the interest of national defense, each county medical society should immediately examine the adequacy of the blood supply in its area.

In some instances, community needs are now being supplied by local blood banks, but these are inadequate to meet the sudden heavy requirements occasioned by disaster, the report pointed out. In addition to these local banks, the American Red Cross has eight regional blood programs now in operation, as well as the Massachusetts statewide program. However, "all these existing facilities taken together are accomplishing only a portion of the civilian need and a very small percentage of the potential need," the American Medical Association committee declared. "There is a real possibility that hurried expansion (of blood collecting facilities) may be forced on us at any time," the statement warned.

Gives $50,000 to George Washington U. for Cancer Research

WASHINGTON, D.C.—The American Cancer Society presented a check for $50,000 to George Washington University June 14 for use in cancer research through the Warwick Memorial. The Warwick Memorial earlier this year established a cancer detection clinic at the new George Washington University Hospital and a cancer clinic and research facilities in the old G.W.U. hospital building.

Dr. Calvin T. Klopp, director of cancer activities for the university school of medicine, listed a number of cancer research projects already underway or pending which will be augmented by the $50,000 gift. Among these activities are:

1. A clinical research unit in which patients will get the best of modern medical care and be under constant observation twenty-four hours a day.

2. A study of the effects of nitrogen mustards (used in cancer-like conditions of the blood and lymphatic system) on the body chemistry.

3. The use of radioactive chemicals (isotopes) to trace blood chemistry in normal and cancerous persons.

4. Microscopic study of cells and the development of technics to detect cancer by smears and washes in the stomach, lungs, uterus, kidneys and other organs.

5. A study of the effect of cancer operations on animals.

6. The testing of drugs on animal cancers.

7. Efforts to develop a penicillin-like substance for the treatment of cancer.

Cutter Resumes Shipment of Intravenous Solutions

BERKELEY, CALIF.—Cutter Laboratories has resumed shipment of intravenous solutions following cancellation of these shipments pending investigation of contamination discovered in some of the company's materials two months ago.

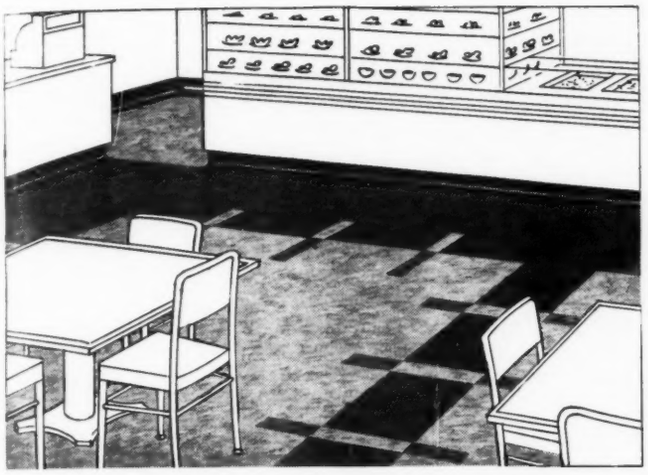
In a company release signed by Fred A. Cutter, it was explained that hundreds of thousands of flasks were critically examined during the investigation period. "Every piece of equipment and every instrument was meticulously checked," the announcement said. "There was no evidence of equipment or instrument failure and we could not definitely confirm closure failure or any other cause for the contamination.

"I can assure you, however, that not a single bottle which was clear on visual inspection has been found to be contaminated and we will continue to do everything in our power to assure the safety that has been the cornerstone of our existence and growth for over fifty years," the company official concluded.

Approve Flight Duty

WASHINGTON, D.C.—Qualified flight nurses, members of the nurse corps, U.S. Naval Reserve (inactive), may now request active service and be assigned to flight duty, according to a recent announcement of Capt. Nellie Jane DeWitt, director, navy nurse corps. They may ask for a two weeks' training duty or for an indeterminate period, the minimum length of which would probably be one year.

Requests for the two weeks' training duty should be submitted to the commandant of the naval district in which the nurse resides; for the indeterminate period, to the Bureau of Medicine and Surgery, Nurse Corps Office, Washington, D.C., via her Naval District.



A FLOOR OF ARMSTRONG'S LINOLEUM is long wearing and decorative. Here a custom design contributes to a pleasant lunchtime setting. Floor colors can blend with the walls and furnishings. Sweeping and periodic washing and waxing keep it looking bright and sanitary.

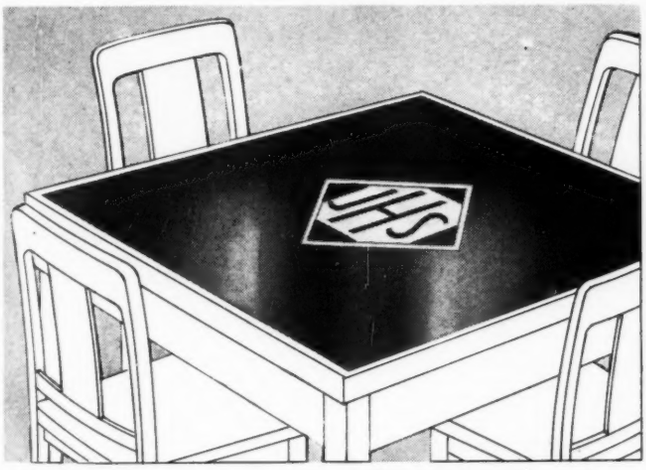
USED ON SERVING COUNTERS, Armstrong's Linoleum provides a sanitary surface. It's especially easy to keep clean. Spilled foods and beverages can be easily wiped up with a damp cloth. This resilient surface helps minimize accidental breakage of dishes and glassware.

See how linoleum serves in school cafeterias

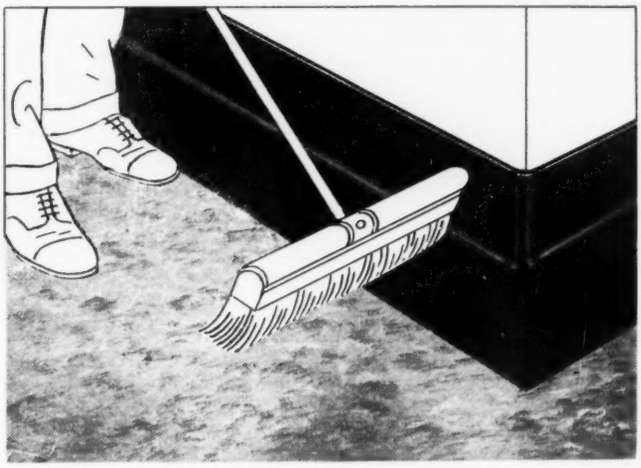
Many special qualities make Armstrong's Linoleum ideal for varied uses in cafeterias. It is durable, decorative, and easily maintained. These qualities make it practical not only for floors but also for table tops and counters, as well.

The economy of Armstrong's Linoleum makes it practical for such general usage. It will give many years of wear with just simple, low-cost care.

For further information about this versatile flooring, see your local Armstrong merchant. He'll be glad to help you plan diversified uses for linoleum in the cafeteria and other rooms throughout your school building.



ON TABLE TOPS, resilient Armstrong's Linoleum resists scratching and marking. It also helps to deaden noise from clattering dishes. If desired, custom insets of your own choice can be used to add extra color and interest.



COVE BASE adds to smart floor appearance and greatly simplifies cleaning. It is formed by curving the linoleum several inches up the walls and sides of permanent fixtures. This eliminates dirt-collecting corners and cracks.

SEND FOR FREE BOOKLET. "Floor Designs for Better Business" gives you many practical ideas for floor planning and care—described and fully illustrated in thirty-two pages. Write Armstrong Cork Company, Floor Div., 3708 State St., Lancaster, Pa.

ARMSTRONG'S LINOLEUM

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Buffalo Hospital Studies Psychological Problems of Handicapped Children

BUFFALO, N.Y.—Children's Hospital here is instituting a new program for the study and treatment of psychological problems believed to retard the recovery and rehabilitation of handicapped children. Establishment of the program, according to Moir P. Tanner, superintendent of the hospital, probably marks the first time any hospital has attempted a fact finding survey coupled with subsequent treatment on such a large scale.

A staff of specialists will devote full time to the study. The staff will consist of a psychiatrist-pediatrician, a psychologist, three medical social service workers, one psychiatric social worker and two medical secretaries. Salaries of the staff and all other expenses involved in the establishment and operation of the program will be paid by the New York State Association for Crippled Children. It is estimated that the first year's operation of the program will cost approximately $30,000.

"Chronic disabling conditions affect not only the physical body of the child, but his whole personality adjustment and often the equilibrium of the entire family as well. Successful medical treatment not only is a question of what the doctor can do for the child but requires active participation of both child and family. If the ill child is discouraged by his condition and feels he will never be like other people his feelings may seriously interfere with his response to treatment," Dr. Sherman Little, director of the child guidance clinic at the hospital, stated.

There is an obvious need for such an intensive and systematic study of the emotional difficulties of disabled children, he added.

Revoke Quinidine Controls

WASHINGTON, D.C.—Formal revocation of the order governing the distribution and use of quinidine and cinchona bark has been announced by H. B. McCoy, director of the Office of Domestic Commerce. At the same time, he warned that the estimated supply of quinidine for the next six months is expected to be insufficient to meet demand for its use in the treatment of cardiac disorders. Any diversion of the quinidine stocks to chill tonics and other less essential products would curtail medical use of the drug.

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Amana Freezer . . .

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. . . "Ends Food Storage Spoilage. Saves Preparation Time."

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N.E.H.A. Delegates Vote $500 Scholarship Fund

DENVER.—A $500 scholarship fund to be placed at the disposal of the University of Maryland was voted by delegates to the eleventh congress of the National Executive Housekeepers Association in Denver, June 23 to 26.

Opening speaker at the business sessions, beginning June 24, was William J. Loeffler, personnel director of the Denver Dry Goods Company, who talked on "The Priceless Qualities of Good Leadership." The afternoon meeting was devoted to discussions by Harry M. Anholt, general manager of the Brown Palace Hotel, on "Public Utility No. 1—the Housekeeper," and by Fred Hughes of Design, Inc., St. Louis, on "Tomorrow's Ideas Today."

The presidents' and delegates' dinners, held at the Brown Palace the evening of the 24th, were highlighted by the presentation of a lei to each member of the group. These had been flown in from Honolulu by Mr. Anholt, who placed them around the neck of each guest.

Friday morning's speaker was Roy R. Prangley, administrator of St. Luke's Hospital, Denver, whose topic was "What Good Housekeeping Means to Hospitals Today." At the banquet which closed the session on Saturday night, the delegates were addressed by Lee Knous, governor of Colorado.

N.E.H.A. convention hostess, Rosalie Soper.

New officers elected for the coming biennial are: president, Edythe Bussey, Schenley Apartments, Pittsburgh; vice president, Helen Walsh, Seaside Hotel, Atlantic City, N.J.; secretary, Mrs. June Malone, Beth Israel Hospital, Boston, and treasurer, Mrs. Delia Tellin, Thames Manor, Pittsburgh. Myrtle Stevens, retiring president, was named to the board of directors, as was also Mrs. Rosalie V. Soper, Brown Palace Hotel, Denver.

The association voted to hold the next congress—in 1950—in Chicago.

Former Interns of Freedmen's Hospital Meet

WASHINGTON, D.C.—Approximately 150 doctors, all former interns of Freedmen's Hospital, held their three-day annual conference here in June. Among speakers who addressed the gathering were: Dr. Albert Harden, associate professor of medicine, Howard University; Lt. Layne S. Harris, National Naval Hospital, Bethesda; Dr. Reginald James, syphilis clinic, Freedmen's Hospital; Dr. Lee E. Sutton, professor of pediatrics, Medical College of Virginia; Dr. Wallace M. Yater of the Yater Clinic; Dr. Charles Garvin, Western Reserve Medical School, and Dr. W. Montague Cobb, professor of anatomy, Howard University Medical School.

Portraits of former chief surgeons of Freedmen's were presented to the hospital in a special ceremony.

Heart Research Bill Signed by President

WASHINGTON, D.C.—Hospitals along with laboratories, universities and other institutions will be mustered into the fight against the Number 1 killer, heart disease, now that the heart research bill has become law with the President's signature June 16. The new law will establish in the U.S. Public Health Service a national heart institute devoted to the study of diseases of the heart and circulation and their cure.

Here is what the institute will do:

It will give grants-in-aid to hospitals and other qualified institutions for research into better treatment and cures for cardiovascular ailments.

It will give similar grants for refresher courses for doctors and for better teaching to medical students.

It will give grants for construction of research facilities.

It will promote coordination of research of all work in these fields.

It will make available for prompt use new information in these fields.

It will make grants-in-aid to states for prevention, treatment, and control of these diseases, and for training of personnel for state and local health work.

It will set up a research center within the Public Health Service.

A National Advisory Heart Council to consist of the surgeon general, the chief medical officer of the Veterans Administration, the surgeon general of the army, the surgeon general of the navy, and twelve outstanding scientists and physicians in the cardiovascular field will assist the institute in the promotion and coordination of research programs relating to the diagnosis and treatment of heart diseases.

The bill carries no funds. The Congress will appropriate the necessary money.

Award A.E.C. Fellowships

WASHINGTON, D.C.—Some forty-four applicants have been awarded Atomic Energy Commission research fellowships, according to a recent A.E.C. announcement. The fellows were chosen by National Research Council fellowship boards set up to administer the A.E.C. financed program. Five classes of research fellowships have been established, including post-doctoral research fellowships in the medical sciences, the biological and agricultural sciences, and the physical sciences; and pre-doctoral research fellowships in the biological sciences and the physical sciences.

Post-doctoral fellowships carry a basic stipend of $3000 per year, while pre-doctoral fellows will receive a basic stipend of $1600 per year. A larger stipend will be granted to provide for support of dependents or other special needs of the fellow.

Drug Committee Reactivated

WASHINGTON, D.C.—World War II Drug Resources Advisory Committee has been reactivated as a move by the army and navy in the direction of industrial preparedness. Working closely with the surgeons general of the army and navy, and with the Army-Navy Medical Procurement Agency, the committee will immediately resume its wartime advisory functions regarding production capacities and sources of medical raw materials in anticipation of civilian needs as well as those of military requirements.

The members will again, as in war time, bear all operating expenses themselves. The committee is set up and maintained as an industrywide function and has no connection with any trade organization.

Carrara Glass walls in this washroom of the Pittsburgh Hospital's new School of Nursing add cheer and beauty; increase sanitation. Architect: Press C. Dowler, Pittsburgh, Pa.

Why walls of Carrara Glass assure greater sanitation

BECAUSE Carrara Structural Glass has a smooth, polished surface—easily cleaned with just a damp cloth . . . because it can be installed in large panels—resulting in fewer joint crevices in which dirt and germs can lodge—progressive hospitals throughout the country have found that walls of Carrara Glass offer greater cleanliness. They have proved particularly successful in increasing the sanitation of operating rooms, laboratories, corridors, kitchens, washrooms, and private-room baths.

And Carrara Glass has other inherent advantages: It will not absorb odors. It will not check, craze, stain, nor fade. It is impervious to grease, chemicals and water. It is an ever-lasting wall material. And since no expensive preparations are required to keep it clean and sparkling, maintenance costs are held at a minimum.

Carrara Glass is available in ten attractive colors, including "Tranquil Green"—a soft, quiet color which is ideally suited to hospital use. A special Suede-finish Carrara softens surface reflections—an effect which is especially desirable in operating rooms.

We suggest you give serious consideration to Carrara Structural Glass—in new construction, as well as in your remodeling plans. Your architect is thoroughly familiar with Carrara Glass, so discuss your ideas with him. Meanwhile, fill in and return the coupon below for our illustrated and informative booklet, "Carrara, the Modern Structural Glass of Infinite Possibilities."

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Arkansas Architects Endorse Hospital Construction Program

LITTLE ROCK, ARK.—A resolution endorsing Public Law 725 and commending its administration in the field of hospital design and construction was passed by the Arkansas Chapter of the American Institute of Architects at a special meeting here last month, Moody Moore, president of the Arkansas Hospital Association and director of the state hospital program, reported.

The Arkansas architect group approved a resolution "endorsing the hospital design and construction program conceived by the U.S. Public Health Service in carrying out the provisions of Public Law 725," and "commending the department's operation in the field of design and construction under the able direction of Mr. Marshall Shaffer."

The resolution further pledged the cooperation of the Arkansas Chapter of the A.I.A. with the state hospital agency in its administration of the hospital program and promised to explore the possibility of cooperating with other states in conducting a hospital planning seminar.

Civilian Scientists Confer With Army Medical Men

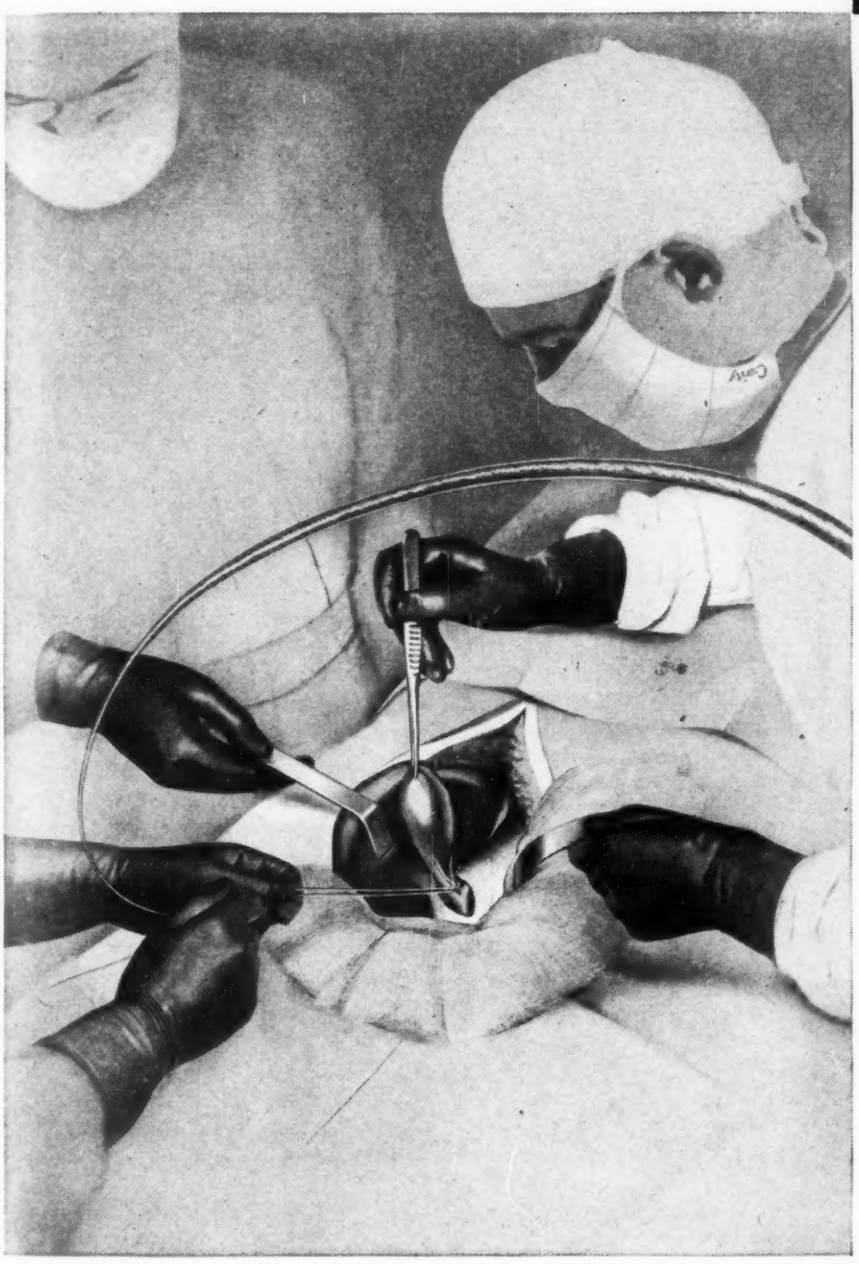
WASHINGTON, D.C.—A conference of more than fifty of the nation's top civilian scientists was held here recently in the Office of the Surgeon General of the Army. The scientists, representing fourteen professional and scientific societies, were called in to advise the surgeon general on recruitment, training and utilization of qualified young scientists to fill 350 specialists' positions now open in the medical service corps of the medical department.

Deputy Surgeon General Armstrong emphasized the need of the medical department for competent research personnel and pointed out that the scientists would work in "a climate of free scientific inquiry, with ample opportunity for professional growth." Greatest need for officer-specialists, he said, is in the fields of bacteriology, biology, biochemistry, chemistry, nutrition, serology, toxicology, physics, clinical psychiatry, psychiatric social work, and other fields allied to medicine.

Presiding at the conference was Maj. F. Roland Kuhn, who has been made chief of the medical allied sciences section of the medical service corps.

The invisible quality of vital importance

SURGICAL USE PROVES PREDICTABLE ABSORPTION OF Curity CATGUT



Curity Catgut has all of the more obvious advantages of fine sutures — smoothness, pliability, more-than-adequate tensile strength and uniformity. These can be seen or felt.

But there is an *invisible* quality in Curity Catgut that is of vital importance in surgical use: *predictable absorption*. Because of it, you can maintain effective wound closure *within a wide margin of safety*—simply by using a Curity suture of the right size and degree of chromicization.

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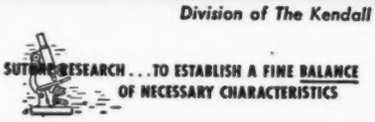

SUTURE RESEARCH . . . TO ESTABLISH A FINE BALANCE OF NECESSARY CHARACTERISTICS

Urges Use of Contagious Disease Hospital for Tuberculous Patients

CHICAGO.—The Chicago Medical Society has recommended that the Municipal Contagious Disease Hospital here be taken over for care of tuberculous patients if investigation indicates such a project is feasible.

The society also voted in favor of making tuberculosis control, now a separate city department, a function of the health department. Dr. Herman N. Bundesen, president of the board of health, is a director of the Municipal Contagious Disease Hospital.

Commenting on the society's proposal, Dr. Bundesen said that an estimated 14,000 people in the metropolitan area are actively infected with tuberculosis, and another 7000 are thought to be borderline cases. The Contagious Disease Hospital has a capacity of 318 beds, Dr. Bundesen said, and last year had an average occupancy of fifty-two patients. However, he pointed out, the hospital has seasonal demands during outbreaks of communicable diseases.

The medical society recorded a vote of confidence for directors of the Municipal Sanitarium and urged that general hospitals accept early cases of tuberculosis for necessary treatment as a means of relieving the pressure for beds.

New England Deaconess to Open Cancer Detection Clinic

BOSTON.—A cancer detection clinic described as the first of its kind in Massachusetts will be opened September 1 at the New England Deaconess Hospital here, Warren F. Cook, executive director of the hospital, has announced.

The clinic will be housed in the Palmer Memorial unit of the hospital pending completion of a six-story cancer institute building now under construction.

"The detection clinic is planned to teach physicians the simplest, most nearly accurate means of finding hidden tumors and potential cancer in their patients," Mr. Cook explained. "It will also contain special facilities for making use of the tools provided by atomic energy in the treatment and study of cancer."

Dr. Shields Warren, head of the pathology department of the hospital and director of the division of biology and medicine of the Atomic Energy Commission, will head the new institute.

Therapeutic Possibilities of Music Under Study

WASHINGTON, D.C.—Music Research Foundation, Incorporated is making a nationwide survey among doctors, hospitals and research institutions in regard to the use of music as a therapeutic agent, according to an announcement June 11. The survey covers member hospitals of the American Hospital Association, American Psychiatric Association members now engaged in the private practice of psychiatry, and colleges, universities and professional schools that have music and/or psychology departments.

The initial survey will be followed by a classification and analysis of current research projects and applied music programs. A practical handbook of methodology will be prepared later. Recommendations of the research committee will be included, based on findings from the foundation's basic research.

In a three-year army authorized project, Music Research Foundation demonstrated under experimental conditions at Walter Reed General Hospital that music's therapeutic possibilities merit serious scientific investigation.

THE ROUTINE USE OF PROSTIGMIN METHYLSULFATE AFTER PELVIC AND ABDOMINAL SURGERY

MEANS MUCH TO ALL THREE

surgeon

The routine, prophylactic use of Prostigmin is sound therapy, since "postoperative abdominal distention is more easily prevented than treated."[1]

patient

If "gas pains" can be minimized and need for the catheter reduced or eliminated, certainly the patient enjoys a smoother, more comfortable convalescence.

nurse

When the prompt use of Prostigmin helps post-surgical patients void spontaneously and reduces the discomforts of distention, floor nurses are saved many calls. And what a blessing that is in these all too busy days!

MEMO TO HOSPITAL DRUG BUYERS
Have you plenty of stock of fast-moving PROSTIGMIN METHYLSULFATE AMPULES and MULTI-DOSE VIALS?

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T. M.—Prostigmin—Reg U. S. Pat. Off. Prostigmin Methylsulfate is the Roche Brand of Neostigmine Methylsulfate, U.S.P.

1. Gordon, E. J. (Surgery, 7:686, 1940)

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ABOUT PEOPLE

(*Continued From Page 78.*)

hospital administration from the University of Minnesota.

Wayne A. Copeland has assumed his duties as superintendent of Mansfield General Hospital, Mansfield, Ohio. His successor as superintendent of Wyoming County Community Hospital, Warsaw, N. Y., is **Robert A. Anderson,** formerly administrative assistant at Johns Hopkins Hospital.

Arthur G. Hennings has been appointed assistant administrator of Northwestern Hospital, Minneapolis, where he will function as comptroller and director of purchasing. A graduate of the University of Minnesota course in hospital administration, Mr. Hennings recently received his master's degree upon completion of his internship at Northwestern Hospital.

B. C. Marshall, formerly superintendent of Hinsdale Sanitarium and Hospital, Hinsdale, Ill., is now administrator at Paradise Valley Sanitarium and Hospital, National City, Calif.

E. E. Martin has assumed the administratorship of the Sid Peterson Memorial Hospital, Kerrville, Tex., now under construction. Mr. Martin served as superintendent of East Dallas Hospital and Clinic, and as resident manager of the Medical and Surgical Clinic in Dallas.

Eloise B. Furnival has been appointed administrative assistant at Muhlenberg Hospital, Plainfield, N. J. A graduate of the program in hospital administration at Northwestern University, Miss Furnival was formerly administrative assistant at Syracuse Memorial Hospital, Syracuse, N. Y.

Norman Skillman has been named assistant administrator at Chester Hospital, Chester, Pa., where he will serve as an aide to **Thomas Leet,** who was named administrator several months ago.

Dwight C. Austin has been appointed administrator of Royal Oak General Hospital, Royal Oak, Mich. Mr. Austin is a graduate of the school of hotel administration, Michigan State College, and for the last year has been serving as administrative assistant at Edward W. Sparrow Hospital, Lansing, Mich.

Dr. James P. Dixon became Director of Health and Hospitals in Denver on July 1 when the administration of the health department of the city and county of Denver and the administration of Denver's city operated hospitals were merged.

Owen B. Stubben has been appointed to the newly created post of assistant director of hospitals for the city and county of Denver. Mr. Stubben is a graduate of the hospital administration course at the University of Minnesota and has recently completed an administrative internship at the Swedish Hospital in Minneapolis.

Dr. Sidney M. Samis has been appointed assistant director, Montefiore Hospital, New York City, effective August 1.

James McKelvey Jr. has assumed the directorship of Grafton City Hospital, Grafton, W. Va.

Clifford L. Huber has been named administrative assistant at Grand Forks Deaconess Hospital, Grand Forks, N. D.

Department Heads

Marjorie R. Quandt, R.R.L., has been appointed chief medical record librarian and director of the school for medical record librarians at Wesley Memorial Hospital, Chicago, to succeed **Mrs. Edna K. Huffman.** A graduate of the College of St. Scholastica, Duluth, Minn., Miss

Quandt received her medical record librarian training at St. Mary's Hospital, Duluth.

Sibba Axford, former superintendent of nurses at Mineral Springs Sanatorium, Cannon Falls, Minn., has replaced **Hannah M. Borgers** as superintendent of nurses at St. Luke's Hospital, St. Paul.

Dr. Loyal Davis has been named chief of staff at Passavant Memorial Hospital, Chicago, succeeding **Dr. Howard Carroll.** Dr. Davis is chairman of the division of surgery at Northwestern University Medical School and since 1925 has been consulting neurological surgeon at Hines Veterans Hospital.

Thomas J. Burns, formerly office manager of the University of Pennsylvania Hospital, has accepted a similar position with Garfield Memorial Hospital, Washington, D.C.

Emma Kelting, R.N., formerly director of nursing at Chicago Lying-In Hospital, is now director of the school of nursing and nursing service at Galesburg Cottage Hospital, Galesburg, Ill. A graduate of the school of nursing at the University of Iowa, Miss Kelting also holds degrees of bachelor of arts and master of science.

Sylvia Haubrich is the new director of nurses and of the school for attendants at Kenosha Hospital, Kenosha, Wis. Miss Haubrich, a graduate of the Kenosha Hospital School for Nurses, has a bachelor of science degree in nursing education from Marquette University, where she has been an instructor in the college of nursing since 1944.

Bernice E. Larson

Bernice E. Larson has assumed the duties of director of nurses at St. Luke's Hospital, Milwaukee. Miss Larson was formerly an instructor on the faculty of the University of Wisconsin School of Nursing.

Mrs. George M. Diffenderfer has been named personnel and public relations director at Carlisle Hospital, Carlisle, Pa.

Mrs. Helen R. Martin, R.N., has been appointed director of the nursing department at Nassau Hospital, Mineola, N.Y. A graduate of the Jackson Memorial Hospital Training School in Miami, Mrs. Martin received her bachelor of science degree at Florida State University and took graduate work at Western Reserve University in Cleveland. **Nellie Sanderson** has been named first assistant to Mrs. Martin.

Lenna F. Cooper has retired from her position as chief of the department of nutrition of Montefiore Hospital, New York City, and will devote herself to private consulting practice. She has been appointed consulting dietitian to Montefiore Hospital.

Mable M. MacLachlan, director of dietetics at University Hospital of the University of Michigan for fourteen years, has resigned to become educational director of the American Dietetics Association.

Mrs. Regina Stuart has been named director of housekeeping at Michael Reese Hospital, Chicago, succeeding **Mrs. Alta M. La Belle,** whose resignation was reported recently. Mrs. Stuart was formerly executive housekeeper at Nelson House, Rockford, Ill.

Trustees

Alvin J. Binkert, who has been comptroller of Presbyterian Hospital, New York City, has been appointed assistant vice president. **Richard N. Kerst,** assistant comptroller, succeeds Mr. Binkert as comptroller.

Miscellaneous

Fred J. Bommer has left the Nix Memorial Hospital, San Antonio, Tex., where he was business manager, to join the staff of the East Tennessee Baptist Hospital, Knoxville, Tenn.

Mrs. Ruth Wetle has been appointed manager of the hospital service department of the Blue Cross Plan for Hospital Care, Chicago, replacing **Margaret Hill,** who resigned. Mrs. Wetle has been with Blue Cross for four years, first as a nurse editor in the hospital service department and later as assistant to Miss Hill. A registered nurse, she received her training in Presbyterian Hospital and served there as staff nurse, as well as at Leland Stanford University in California.

Benjamin F. Hirsch has been reelected president of the Manufacturers' Surgical Trade Association. Also reelected were **John MacGregor,** first vice president; **G. P. Snow,** second vice president; **H. Y. Grabau,** secretary, and **E. W. Roehm,** treasurer.

Roy W. Walholm has been appointed executive vice president of Evanston Hospital, Evanston, Ill. In his newly created position, Mr. Walholm will organize and direct extensive plans for expansion of the hospital.

Martha M. Bailer, who recently resigned as director of the medical record department, Children's Hospital of Michigan, Detroit, has been appointed executive secretary of the American Association of Medical Record Librarians, Chicago.

Albert Pleydell resigned as general manager of the Health Insurance Plan of Greater New York on July 1 in order to become associated with Survey Institute, New York.

Deaths

Robert B. Witham, administrator of Scripps Memorial Hospital, La Jolla, Calif., died July 4. From 1943 to 1947 Mr. Witham was head of Lincoln General Hospital, Lincoln, Neb. He resigned that position to join the staff of the U. S. Public Health Service, with headquarters in San Francisco, and later went to La Jolla.

During the war Mr. Witham was special civilian assistant to the commanding general at Fitzsimons General Hospital, Denver. He had been active in hospital administration for more than twenty-five years and was a charter fellow of the American College of Hos-

Hospitals approve Ivory's "bedside manner"

Like an experienced doctor or nurse, Ivory Soap has the perfect bedside manner. It has qualities which contribute to the comfort of bed weary patients. It's business-like, but gentle. It has no useless frills. It inspires confidence.

Small wonder that Ivory has itself become an "institution" in so many, many institutions dedicated to the healing of the sick. Small wonder that *more doctors advise Ivory Soap* than all other brands put together.

99 44/100% pure - it floats

Pure, mild, rich lathering Ivory Soap is available for hospital use in a choice of 5 convenient sizes: First choice in the big majority of hospitals is the generous, unwrapped 3-ounce size.

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Maternal Mortality Rate Continues to Decline

WASHINGTON, D.C.—The decrease in the maternal mortality rate in 1946 as compared to 1945 was 24 per cent, according to figures, released June 4, by the National Office of the Bureau of Vital Statistics. In 1946, 5153 women died in the United States from causes related to pregnancy and childbirth. In 1945, 5668 women died from such causes. The national maternal mortality rate has been steadily declining since 1930 when the rate was 6.7 as against 1.6 in 1946.

The maternal mortality rate is much lower, and is decreasing more rapidly, among white than among non-white women. The rate is higher in rural areas than in urban. Connecticut had the lowest maternal mortality rate in 1946; Mississippi, the highest.

Meantime, the rate of babies being born during the first four months of 1948 continued at a high level. Estimates for the continental United States indicate a birth rate (computed on an annual basis) for the first four months of this year of 23.7 per 1000 population, including the armed forces overseas.

Murray Sargent Honored

NEW YORK.—Murray Sargent, president of the Greater New York Hospital Association, was honored recently for his outstanding work in the Greater New York Fund campaign when he was presented with a citation for meritorious service to the fund's 1948 appeal. Mr. Sargent took an active part in the fund's campaign and headed the committee which canvassed the hospitals throughout Manhattan. The fund raised $5,011,462 during the six weeks of intensive citywide solicitation.

V.A. Hospital at Denver

WASHINGTON, D.C.—Bids for the construction of a 500-bed veterans' hospital at Denver will be opened here August 17. The hospital is intended for general medical and surgical patients, although treatment of all types of patients is included in the plans. The main hospital will have nine floors, full basement, and a penthouse.

BOOKSHELF

WIDENING HORIZONS IN MEDICAL EDUCATION. *A report of the Joint Committee of the Association of American Medical Colleges and the American Association of Medical Social Workers. Jean A. Curran, M.D., and Eleanor Cockerill, co-chairman. Cloth. Pp. 228. Price, $2.75. New York: The Commonwealth Fund,* 1948.

The problem to which this report seeks the answer is one that concerns hospital administrators, nurses and departmental executives, as well as physicians, educators and social workers, for whom the report is primarily intended. The problem is fully stated in this paragraph from the committee's opening statement of principles: "Since the greater part, if not all, of clinical instruction has been confined to the hospital, it has been difficult to emphasize properly to the student the importance of the factors in the patient's home and community having a bearing on his illness. The patient comes to the hospital with his medical complaints but leaves his environment at home. The clinical clerk sees the patient dressed in a fresh hospital gown, lying in a clean bed in the hushed atmosphere of the hospital. . . . It is small wonder then that the medical student does not become aware

of the social aspects of medicine unless a conscious effort is made by his teachers to awaken him to the importance of these factors."

With detailed studies of existing methods and technics, the remainder of the report is devoted to describing how the problem has been attacked in several medical schools. A number of case histories are included throughout the report to show how medical students have been made to realize that the social factors of illness must be understood before the physician can "consider the patient as a person." Hospital and nursing executives could study these histories with profit. At the very least, this report should become required reading for all students of hospital administration.

YOU AND YOUR DOCTOR. *By Benjamin F. Miller, M.D. Cloth. Pp.* 183. *Price,* $2.75. *New York: Whittlesey House,* 1948.

Here are all the familiar, and often cogent, arguments proving that medical care for the American people is not as good as it ought to be. With simple eloquence and devastating effect, for example, Doctor Miller has described a day in the life of a typical, conscientious, overworked general practitioner who must do the best he can against odds compounded of too many patients, inadequate help and facilities and lack of time for self-education and consultative aid in problems that are beyond his knowledge and skill. Instead of the fatigued, discouraged and often bewildered practitioners who care for many of our illnesses now, Dr. Miller argues, we should have an unhurried, competent team of specialists, a group practice unit built around the "pilot physician"—the author's term for a general practitioner functioning mainly as diagnostician, with emphasis on the psychosomatic approach.

Few readers will deny that Dr. Miller's picture of medical care as it should be is an attractive one, but not many doctors or hospital people will like the bridge he has built to get from where we are to where he wants us. Dr. Miller thinks it can all be accomplished by federal aid. He would provide liberal grants for medical education and research, special funds for families whose lives are disrupted by illness, a government disaster service, and health insurance for all, administered by the U.S. Public Health Service. Like many others who advocate these sweeping reforms, Dr. Miller doesn't dwell on their evils and hazards. In fact, he doesn't even mention them—a circumstance which makes his case less persuasive, rather than more so, to the thoughtful reader.

THE ASEPTIC TREATMENT OF WOUNDS. *By Carl W. Walter, M.D. New York: The MacMillan Company,* 1948.

Dr. Walter, who has long been recognized as one of the authorities in the field of aseptic technic, is the author of this new and important book.

The first chapter is of considerable interest to those who are interested in medical history because it clearly traces the evolution of asepsis from 1728 to the present.

The remainder of the book is a composite of present day technics in sterilization and asepsis. It runs the entire gamut from transfusions through sutures, syringes and sterilizers. There are instructions for packaging of sets and maintenance of equipment. The book is well illustrated with simple yet effective drawings.

A copy of this book should be in the hospital library or the operating room.

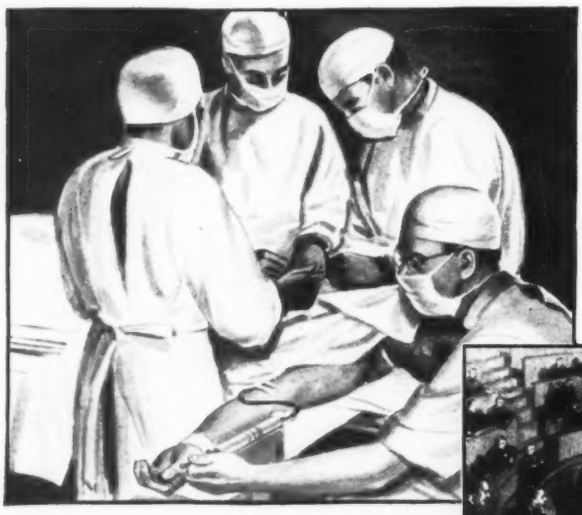
—ROGER W. DEBUSK, M.D.

NEWS . . .

Three Iowa Hospitals Affiliate With Drake U.

DES MOINES, IOWA.—Iowa Methodist Hospital, Mercy Hospital and Broadlawns Polk County Hospital here have completed an affiliation of their schools of nursing with Drake University, it was announced recently. Under the affiliated program Drake University will teach six courses of the school curriculum on the Drake campus. Anatomy and physiology, chemistry, microbiology, pharmacology, psychology and sociology will be taken in a newly completed science building on the university campus. At the completion of their school of nursing curriculum, graduates of the school will be granted thirty credit hours toward a bachelor of science degree, or forty-eight hours toward a bachelor of education degree at the university.

Tuition costs to the students were increased somewhat, but the hospital authorities stated that the increased tuition had no apparent deterring effect on applicants for admission to the fall classes. "Prospects for the fall classes are unusually good," said D. W. Cordes, administrator, Iowa Methodist Hospital. "It appears that students today are attracted by high quality instruction and university credit towards academic degrees. They seem able to find the funds to meet the increased cost. Student loan funds which have been available for years are infrequently drawn upon."



1948 . . . sodium pentothal being injected into vein of chest case patient prior to operation

1847 . . . ether administered by a sponge soaked with the drug

Bettman Archive

Two Medical Societies Condemn Hospitals for "Practice of Medicine"

CHICAGO.—Recent developments in the battle of militant language between hospitals and medical societies included resolutions by two state medical groups condemning the "practice of medicine by hospitals."

The Missouri Medical Association recently resolved that the "corporate practice of medicine (on the part of hospitals and medical schools) is a professional evil second only in its consequences to socialized medicine" and instructed its delegates to the American Medical Association to "remove every hospital engaged in the practice of medicine from its list of hospitals approved for internship and residency training."

The house of delegates of the Medical Society of the State of New York adopted a resolution requesting the society's council "to use its efforts to prevent hospitals from practicing medicine and interfering with the private practice of medicine and to use all moral and, if necessary, legal methods for this purpose."

Chicago Schools Start Practical Nursing Course

CHICAGO.—The Community Council on Nursing in cooperation with the Chicago Board of Education is preparing a course in practical nursing to be offered by the board of education, Ray Brown, superintendent of the University of Chicago Clinics, announced at a meeting of the Chicago Hospital Council here.

The course will cover forty-six weeks, divided equally among classroom, work in the nursing arts and clinical practice in selected hospitals—probably those without schools of nursing. Hospitals are contributing supplies and equipment for the course, Mr. Brown said, and the board of education will pay salaries of instructors.

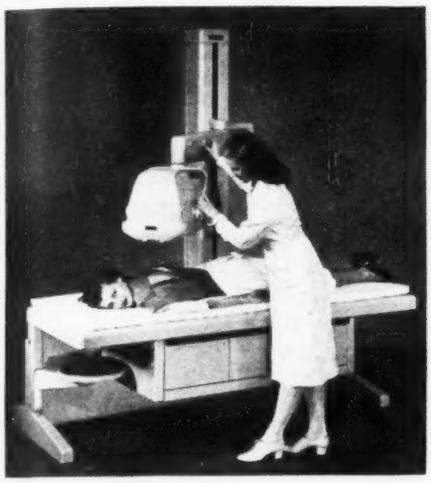
Twenty students have been accepted for the first class, it was announced, and an additional class of twenty will be enrolled after the first twenty-three weeks.

What's New FOR HOSPITALS

JULY 1948 Edited by BESSIE COVERT

For further information on new products see coupon on page 223

Maximar 100 X-Ray Therapy Unit



The Maximar 100 x-ray therapy apparatus is new in both operation and design. It is a superficial therapy unit, designed especially for the treatment of skin ailments, which provides more than three times the quantity of radiation per minute in earlier models. The tube and its stand can be adjusted to any desired position and locked into place with slight hand pressure. It produces a high proportion of long wave length radiation, which does not penetrate the surface, thus indicating its value for skin work.

The modern exterior design is streamlined and finished in a soft pearl shade, glossy finish for attractive appearance and ease of cleaning. Matching controls have instruments grouped for maximum ease and efficiency of operation within mechanical and structural limitations and dials are illuminated by light-transmitting plastics. **General Electric X-Ray Corp., Dept. MH, 4855 W. McGeoch, Milwaukee 14, Wis. (Key No. 1)**

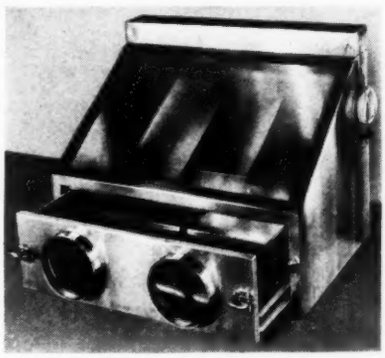
New Package for A.S.R. Surgeon's Blades

The new "Command Edge" A.S.R. Surgeon's Blades are now available in a new package which seals them against moisture and other climatic and storage hazards which might otherwise damage them when kept over long periods of time.

Developed during the war to safeguard fine blades and other equipment in tropical climates, the new package consists of a hermetically sealed aluminum foil wrapping covering the heavy wax paper which forms the first protection to the blades. Over the foil is sealed a thin layer of cellophane. Until the seal is broken, the blade is permanently protected against moisture and similar potentially harmful conditions, thus making it possible to order blades in larger quantities and keep them safely in storage. **American Safety Razor Corp., Dept. MH., 315 Jay St., Brooklyn 1, N. Y. (Key No. 2)**

Erie Glove Powdering Box

The Erie Glove Powdering Box, for powdering gloves before wrapping, has a removable drawer which operates freely on stainless steel channels and is equipped with self-closing catches. The plate glass front is set in rubber retaining channels and a



shadowless fluorescent light illuminates the interior. Comfortable armholes permit freedom of movement and the fabric sleeves prevent powder from escaping. The box is finished in polished stainless steel for long wear, ease of cleaning and attractive appearance. **S. Blickman, Inc., Dept. MH, Weehawken, N. J. (Key No. 3)**

Foilclad Pipe Units

Ric-wiL Foilclad Pipe Units have been developed for overhead distribution of steam or liquids. The units are completely prefabricated at the factory, specified types of insulation being used. The pipe is machine coated with high temperature asphalt, tension wrapped with asphalt-saturated asbestos felt, coated a second time with asphalt and tension wrapped with aluminum or copper foil which forms a perfect bond with the asphalt. The unit is thus completely waterproof and weather protected. It is shipped in 21 foot sections, ready for installation. **The Ric-wiL Co., Dept. MH 1082B, Cleveland 14, Ohio. (Key No. 4)**

Aluminum Steam-Jacketed Kettles

The new Wear-Ever Aluminum Steam-Jacketed Kettles are designed to provide faster cooking at lower steam pressures because of the speed with which aluminum conducts heat. The new shape combines the best features of the shallow and deep type kettles, taking up less installation space and giving greater capacity per foot of floor space. The adjustable feet give perfect leveling.

Both the front and rear sections of the sanitary "hinged type" cover on the 80 gallon size kettle can be opened while the whole cover is easily removed. The new enclosed hinge channel is designed to prevent fluids on the cover from running into the kettle when the cover is opened and the cover extends over kettle bead for easy cleaning. The sanitary single piece cover on the smaller kettles has welded hinge pads and this cover also extends over kettle bead.

Other features of the new kettles include shell and jacket drawn from a single sheet of thick, hard 528 aluminum alloy, special sanitary draw-offs which can be quickly removed and dismantled into three parts for easy cleaning, shut off close to kettle base to prevent food remaining uncooked in tube,

and goose neck fitting. **The Aluminum Cooking Utensil Co., Dept. MH, New Kensington, Pa. (Key No. 5)**

The Fisher Anhydrator

The Fisher Anhydrator dries x-ray films without the use of heat. Clean filtered air at extremely low humidity is circulated at high speed within the closed system, drying films in an average of 10 minutes, regardless of external temperature or climatic conditions. The moisture absorbed by the air is extracted without heat by a unique anhydrating agent and then recycled to the drying compartment. Surface temperature of films does not rise above 70 degrees F. during the drying process.

The unit is completely self-contained, introducing no room air during operation and requiring no exhaust of moisture-laden air. It will handle up to 24 x-ray films 14 by 17 inches at one loading and the standard racks accommodate films of any smaller size. The Anhydrator occupies only 2 feet by 3 feet 6 inches of floor space and requires no other installation than plugging into standard alternating or direct current. **Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 6)**

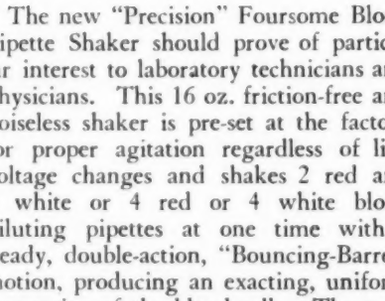
Ethicon Sterile Pack Sutures

Time required to scrub non-boilable standard tube sutures in the operating room and to clean tubes and suture jars periodically can now be saved by the use of the new Ethicon Sterile Pack Sutures. The new hermetically-sealed metal canisters contain 6 dozen standard tubes of Ethicon Non-Boilable Surgical Gut, U.S.P., immersed in sterile storage fluid. Each canister contains sutures all of one type and size. Type A, Plain and Type C, Medium Chromic are supplied in the new package in sizes 000, 00, 0, 1 and 2.

The Sterile Pack canister is quickly and easily opened by a key attached to the top, and a reusable chrome metal cover, which can be readily sterilized, is used to cover the canisters after they have been opened. All tubes are covered in the canister with an antiseptic storage fluid capable of sterilizing and maintaining sterility before as well as after the canister seal is broken. The fluid from used canisters can be used in partly empty ones to keep the fluid at the proper level. Breakage of tubes in handling is minimized with the new procedure, no suture jars are required and each canister is clearly marked on the outside to show the contents. **Ethicon Suture Laboratories, Dept. MH, New Brunswick, N. J. (Key No. 7)**

Blood Pipette Shaker

The new "Precision" Foursome Blood Pipette Shaker should prove of particular interest to laboratory technicians and physicians. This 16 oz. friction-free and noiseless shaker is pre-set at the factory for proper agitation regardless of line voltage changes and shakes 2 red and 2 white or 4 red or 4 white blood diluting pipettes at one time with a steady, double-action, "Bouncing-Barrel" motion, producing an exacting, uniform suspension of the blood cells. The non-leaking pipettes can be dropped into



place and lifted out when the shaker is in motion.

The shaker has no motor and no moving parts to get out of order. It is mounted on a rubber base, enclosed in an all-rubber housing and is constructed to withstand long, hard usage. **Precision Scientific Co., Dept. MH, 3737 W. Cortland St., Chicago 47. (Key No. 8)**

Durolier Germicidal Lamps

Durolier Germicidal Lamps are designed to kill bacteria in the air. Type A is the standard germicidal lamp and type B provides a small amount of ozone for deodorizing purposes.

These lamps are similar to fluorescent lamps in size and electrical characteristics but use a special ultraviolet transmitting glass for the passage of the ultraviolet rays. They are designed to be easily installed on the wall above eye level. The lamps are finished in hard-baked ivory enamel with aluminum trim and reflectors of highly polished Alzak aluminum. **Duro-Test Corp., Dept. MH, North Bergen, N. J. (Key No. 9)**

Chocolate Dispenser

The new Amcoin hot chocolate urns have the All-Glass interior features of Amcoin coffee urns. Automatic agitation keeps the chocolate thoroughly mixed, thus giving each cup served the same consistency. Thermostatic control keeps the chocolate at the right temperature and the new urns, one and two gallon capacity, save time and effort in service while providing a uniformly mixed beverage. **Amcoin Corp., Dept. MH, 1148 Main St., Buffalo 9, N. Y. (Key No. 10)**

Flex-Straw

The new Flex-Straw, for the ingestion of fluids, is sanitary, disposable, unbreakable, adaptable and economical. The generous size straw is dipped in a high temperature-resistant microcrystalline wax which is tasteless and odorless but which gives the straw a firmness which, in tests, has held up, even in hot liquids, for 24 hours. An accordion pleating effect near the top of the Flex-Straw permits the straw to be bent into any desired position. **Flex-Straw Corp., Dept. MH, 4300 Euclid Ave., Cleveland 3, Ohio. (Key No. 11)**

All-Metal Soap Dispenser

Bobrick Model 12 liquid soap dispenser is made of highly polished Monel metal, which does not rust or corrode, to meet the hard service requirements of hospitals and other institutions. This all-metal unit is virtually indestructible and has a capacity of over one quart.

The new dispenser has the Bobrick 860 valve, concealed wall fastening to make it theftproof, large hinged filler cap, and unbreakable "eye" to indicate time to refill. The design of the wall fastening makes it possible for the dispenser to be attached with screws or

with plastic rubber adhesive. **Bobrick Mfg. Co., Dept. MH, 1839 Blake Ave., Los Angeles 26, Calif. (Key No. 12)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 223

Doctors' Paging System

The new IBM Doctors' Paging System is so designed as to meet the paging requirements of any size hospital. It consists of a selector keyboard, on which the doctor's code number is set when he is to be paged and a control panel and annunciators placed in corridors, office areas and rooms. When the doctor is paged his code number is flashed on all annunciators. Three different calls may be flashed in sequence or all the indications on the annunciators may be flashed together in case of emergency. The paging control operator sounds a buzzer or chime to attract attention when the call is not answered promptly. **International Business Machines Corp., Dept. MH, 590 Madison Ave., New York 22. (Key No. 13)**

Circline Fluorescent Lamps

Two new desk lamps with 32 watt circline fluorescent bulbs have been announced. Both models are equipped with 90 per cent or better power factor correct ballast, radio condenser and manual starting switch.

Model No. 20101 is 19 inches high with a 6 inch diameter base and shade 14¾ by 4 inches. The lamp is finished in satin chrome and gold. Model No. 20103 is 17 inches high with a 7¼ by 4½ inch base and shade 14 by 3 inches. It is finished in rippled gray and chrome or electroplated statuary bronze and has a removable receptacle which can be used for pen and pencil rest or as an ash tray. **Faries Manufacturing Company, Dept. MH, Decatur, Ill. (Key No. 14)**

Slide Projectors

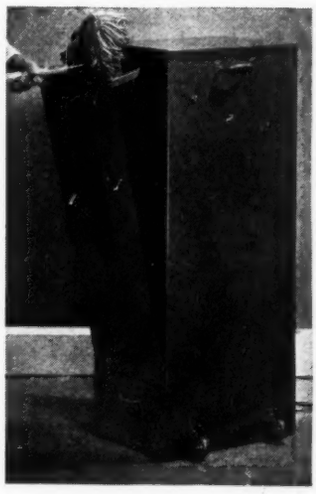
"TDC Vivid" is the name given a series of 2 by 2 inch slide projectors

recently announced. They are designed for brilliant and efficient projection and for operating ease. A new shutter-type slide carrier cuts off light while slides change; slides feed from right and eject from left; and the new models are convertible from 150 to 300 watts with optional fan cooling unit. The exterior is of modern, streamlined design. **Three Dimension Sales Co., Dept. MH, 4555 W. Addison St., Chicago 41. (Key No. 15)**

Irrigation Rod

The new Hard portable irrigation rod has safety hooks on each end of a T-bar to prevent the bale rod of a solution container being accidentally knocked out. Two thumb screws are used to control the clamps for attaching the rod firmly to gatch spring beds. A center hook is provided to hang the rod in the storage room when not in use. **Hard Mfg. Co., Dept. MH, 117 Tonawanda St., Buffalo 7, N. Y. (Key No. 16)**

Dust Mop Cleaner



A new portable dust mop cleaner, which traps the dust in an easily emptied drawer, has been announced. The dusty mop is inserted in the machine, the switch is turned and the mop is cleaned in a few seconds of all loose dirt and lint in such manner that the dust is completely trapped for later disposal and that mops require less frequent washings.

Equipped with the Haynes suction method of dust extraction, the tight metal cabinet has a quiet, slow speed air turbine which pulls the dust from the mop to a filter. It is sturdily constructed for long service and is equipped with a 110 volt AC motor. The mop cleaner is readily moved with other housekeeping equipment as it is used and should save time and effort while making dusting operations more effective. **The Markham Mfg. Co., Dept. MH, 1392 W. 110th St., Cleveland 2, Ohio. (Key No. 17)**

O.E.M. Mechanaire

The O.E.M. Mechanaire is a new type Iceless Oxygen Tent designed for the easy, safe, convenient and accurately controlled continuous administration of oxygen. The Mechanaire is a 1/3 h.p. hermetically sealed field serviceable unit which, if necessary, can be repaired at the hospital. The hermetically sealed compressor unit is guaranteed for one year and the equipment is designed to maintain oxygen concentration at the prescribed flow while allowing for cooling and de-humidification.

The unit has aluminum finned refrigerant coils, built to E.O.M. specification and high-pressure-tested at 2800 pounds to ensure against possibility of leakage. The Mechanaire is extremely light and easily transported. It is of aluminum construction, insulated to prevent both cold loss and sweating, is equipped with easy-rolling, ball-bearing rubber tire casters for effortless movement and it requires a minimum of storage space when not in use. The simplified panel control has a convenient outside dial thermometer for quick, easy temperature reading throughout the operation of the unit, a smoothly operating switch, pilot light, oxygen inlet and oxygen testing outlet. **Oxygen Equipment Mfg. Corp., Dept. MH, 405 E. 62nd St., New York 21. (Key No. 18)**

Redesigned Sero-Scope

The new Model 300 Sero-Scope for the examination of test tubes applies the same principle of using a constant temperature block as the earlier model, but it has a wider application and is lower in cost. The optical system and rotating head have been eliminated and the new model has space for 48 Kahn tubes. **W. R. Lammerson, Dept. MH, 4761 Hollywood Blvd., Los Angeles 27, Calif. (Key No. 19)**

Pharmaceuticals

Thenylene Hydrochloride

Thenylene Hydrochloride is announced by Abbott Laboratories as a new synthetic drug with marked antihistaminic properties and a comparatively low incidence of side-effects. It is designed for use in the treatment of allergies where the release of histamine or histamine-like substances is suspected. The product is supplied in 50 mg. and 0.1 Gm. tablets in bottles of 100 and 500. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 20)**

Heavy Nupercaine

Heavy Nupercaine is a new spinal anesthetic which has proved successful in saddle block anesthesia in obstetrics and various surgical procedures. It is a hyperbaric solution of Nupercaine and dextrose which is available in 2 cc. ampules. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 21)**

Liquid Hematinic

Liquid Hematinic is a new liquid preparation of liver extract, iron and vitamin B complex, developed for treatment of secondary and nutritional anemias. It has a pleasant taste which is an asset in administration to children. It is supplied in pint and gallon bottles. **Ulmer Pharmacal Co., Dept. MH, 412 S. Sixth St., Minneapolis 15, Minn. (Key No. 22)**

Vodine

Vodine is an iodine antiseptic ointment designed to prevent or combat infection by surface application. It is indicated wherever the action of iodine is desirable. Vodine is a stable formulation of iodine in Solubase, a thermostable ointment base of high solvent power and water miscibility. It is available in 4 and 8 ounce jars. **Vodine Company, Dept. MH, 407 S. Dearborn St., Chicago 5. (Key No. 23)**

Mercodol Cough Syrup

The improved narcotic, Mercodinone, is used in the new Mercodol cough syrup to inhibit the cough reflex without completely suppressing it. The bronchodilator Nethamine and the sedative-expectorant, sodium citrate, are combined with Mercodinone in a palatable syrup base to provide balanced cough relief. The new syrup is available in pint and gallon bottles. **The Wm. S. Merrell Co., Dept. MH, Cincinnati 15, Ohio. (Key No. 24)**

Product Literature

• Two **Conversion Charts** for converting pounds to grams have been prepared by The Gordon Armstrong Company, Inc., 1501 Euclid Ave., Cleveland 15, Ohio. Carefully figured to four decimal places, the charts have been checked for accuracy and are figured on the basis of 1 ounce equalling 28.3495 grams. Two styles are available, one punched for a three-ring binder for use in students' notebooks and the other on a heavier card which can be fastened to the wall with thumb tacks. The latter style has a plastic coating which can be kept clean by wiping with a cloth. The charts are offered at a nominal charge but are sent gratis to hospitals using the Armstrong X-4 Baby Incubator. **(Key No. 25)**

• The new **Zimmer Fracture Chart,** available to hospital and professional personnel, is a handy reference chart designed to be hung on the wall. The proper splints and appliances for various types of fractures are described and pictured in this helpful guide offered by Zimmer Mfg. Co., Warsaw, Ind. **(Key No. 26)**

• The revised 60 page bulletin on **"Equipment and Materials for Conditioning Water and Other Liquids"** issued by Liquid Conditioning Corp., Dept. MH, 114 E. Price St., Linden, N. J., describes modern methods and apparatus for conditioning water and other liquids. The material has been brought up-to-date to include the most recent developments in the design of water treatment and liquid conditioning equipment and the applications, advantages and limitations of the different types are described. Tables listing the various kinds of impurities, showing the effects, limits of tolerance, methods of removal and residual amount after treatment with a comparison chart showing the chemical results produced by various water treatment methods are included in Bulletin G-1. **(Key No. 27)**

• **"Hays Electronic Type Recording Instruments for Oxygen, Carbon Dioxide, Temperature and Pressure"** is the informative title of the new catalog issued by The Hays Corporation, Michigan City, Ind. Known as Bulletin 48-829, the catalog is illustrated with photographs and diagrams to tell the story of this comprehensive line of electronic recording instruments. **(Key No. 28)**

• Corodex, a liquid chemical process for removing rust from any ferrous metal and corrosion from brass, bronze, copper, steel and other surfaces is described in a **"Manual of Rust Control"** issued by Allied Products Co., 1133 Newport Ave., Chicago 13. **(Key No. 29)**

• **A Metric and Apothecaries' Equivalents Chart** has been published by Eli Lilly and Company, Indianapolis 6, Ind. Printed on cardboard and designed for hanging on the wall, the chart offers a convenient reference for converting weights and measures commonly used in medicine and pharmacy. The chart, known as No. DSR-127, is available to pharmacists, physicians, nurses and others in the hospital requiring this type of data for their work. **(Key No. 30)**

• An informative booklet on **"Latex Foam,"** the rubber cushioning material, has been published by the Rubber Development Bureau, 1631 K St. N. W., Washington 6, D. C. Described as "a fact summary on Latex Foam," the booklet covers such subjects as what latex foam is, how it is made, its uses, advantages, sources and the supply available. **(Key No. 31)**

• Two reference books which should be of particular value to the administrator planning a new building or any modernization, as well as to architects, engineers and building committees, have been issued by Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich. One is the **Fenestra Blue Book of Steel Windows and Doors** giving complete specifications and detailed information on all types of steel windows and doors and the other, **Fenestra Blue Book of Steel Building Panels,** provides similar details on steel building panels for floors, walls, roofs and partitions. **(Key No. 32)**

• **"Doehler Tubular Furniture"** is the title of a comprehensive catalog issued by Doehler Metal Furniture Co., Inc., 192 Lexington Ave., New York 16. This 44 page Catalog No. 94 gives sizes and specifications of chromium plated steel furniture, anodized aluminum furniture, chromium plated aluminum furniture and baked enamel steel furniture. Information on the line of costumers, smokers, sand urns and lamps offered by this company is also included as is a fabric color card with swatches of DuPont upholstery fabrics available on Doehler furniture. Illustrations of the upholstered furniture are shown in color. **(Key No. 33)**

• The British Information Services, 30 Rockefeller Plaza, New York 20, is offering a 16 mm. film entitled **"Blood Transfusion 1947,"** for the use of hospitals in teaching and public relations work. The film runs for 17 minutes, 2 reels, and covers a survey of blood transfusion and its development in international medical history, the setting up of the blood donor scheme in Britain and blood bank practice in the United States. **(Key No. 34)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 223

• A compact slide-rule guide for proper floor finishing and maintenance is offered by S. C. Johnson & Son, Inc., Racine, Wis. Known as **"Johnson's 3-Step Floor Finishing Selector,"** the guide is designed for those responsible for floor finishing and maintenance and is operated by merely moving the slide up or down. Information on the proper finishing materials, application methods and reasons for them are given. **(Key No. 35)**

• A study of **"The Exhaust-Water Spray Fire Protective System for Wallways"** has been made jointly by Otis Elevator Co., Westinghouse Electric Corp. and Grinnell Co., Inc. The three firms cooperated in developing the technic, using an exhaust system and a curtain of water, and in publishing the booklet which tells the complete story of the developments and demonstrations. It is available from the Otis Elevator Co., 260 Eleventh Ave., New York 1. **(Key No. 36)**

Book Announcements

The Commonwealth Fund, 41 E. 57th St., New York 22. Report of the Joint Committee of the Association of American Medical Colleges and the American Association of Medical Social Workers, "Widening Horizons in Medical Education," 242 pp., $2.75. Allen, "Medical Education and the Changing Order," 153 pp., $1.50. Report of The New York Academy of Medicine Committee on Medicine and the Changing Order, "Medicine in the Changing Order," 258 pp., $2. Jensen, Weiskotten and Thomas, "Medical Care of the Discharged Hospital Patient," 94 pp., $1. Richardson, "Patients Have Families," 426 pp., $3. Robinson, "The Patient As a Person: A Study of the Social Aspects of Illness," 437 pp., $3. **(Key No. 37)**

The Macmillan Company, 60 Fifth Ave., New York 11. Parsons and Duke-Elder, "Diseases of the Eye," 11th Ed., 732 pp., $7. **(Key No. 38)**

The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md. Amberson and Smith, "Outline of Physiology," 2nd Ed., 510 pp., $5. **(Key No. 39)**

Suppliers' Plant News

Ceco Steel Products Corporation, manufacturer of metal construction products, announces removal of its general offices from the firm's Plant No. 1 to a new office building at **5601 W. 26th St., Chicago 50.** The new office building is part of a general company expansion program which includes an addition of 50,000 square feet of manufacturing space to Plant No. 1, a new warehouse bay added to the Ceco plant at 1450 Mirasol St., Los Angeles, and a new plant and office building at 1902 Weber St., Houston, Tex., **(Key No. 40)**

Cutter Laboratories, Berkeley 1, Calif., announces the resumption of shipment of Cutter solutions in Saftiflasks from its Berkeley and branch warehouses as of June 21 last. **(Key No. 41)**

Goodall Fabrics, Inc., 525 Madison Ave., New York 22, announces the opening of the new Goodall Fabric showrooms on the second floor of the Western Merchandise Mart, San Francisco. Designed by Miss Eleanor LeMaire, the space has modern color, lighting and arrangement and includes reception room, general showroom, private showrooms and executive and sales offices. **(Key No. 42)**

Mercer Glass Works, Inc., manufacturer of hospital, laboratory and surgical specialties, announces removal from 17 W. 17th St. to larger quarters at **725 Broadway, New York 3. (Key No. 43.)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 1 Maximar 100 X-Ray Therapy Unit
- ☐ 2 New Surgeon's Blades Package
- ☐ 3 Erie Glove Powdering Box
- ☐ 4 Foilclad Pipe Units
- ☐ 5 Aluminum Steam-Jacketed Kettles
- ☐ 6 The Fisher Anhydrator
- ☐ 7 Ethicon Sterile Pack Sutures
- ☐ 8 Blood Pipette Shaker
- ☐ 9 Durolier Germicidal Lamps
- ☐ 10 Chocolate Dispenser
- ☐ 11 Flex-Straw
- ☐ 12 All-Metal Soap Dispenser
- ☐ 13 Doctors' Paging System
- ☐ 14 Circline Fluorescent Lamps
- ☐ 15 Slide Projectors
- ☐ 16 Irrigation Rod
- ☐ 17 Dust Mop Cleaner
- ☐ 18 E.O.M. Mechanaire
- ☐ 19 Redesigned Sero-Scope
- ☐ 20 Thenylene Hydrochloride
- ☐ 21 Heavy Nupercaine
- ☐ 22 Liquid Hematinic
- ☐ 23 Vodine
- ☐ 24 Mercodol Cough Syrup
- ☐ 25 Conversion Charts
- ☐ 26 Zimmer Fracture Chart
- ☐ 27 Bulletin G-1
- ☐ 28 Bulletin 48-829
- ☐ 29 "Manual of Rust Control"
- ☐ 30 Metric and Apothecaries' Equivalents Chart
- ☐ 31 "Latex Foam"
- ☐ 32 Fenestra Blue Books
- ☐ 33 "Doehler Tubular Furniture"
- ☐ 34 "Blood Transfusion 1947"
- ☐ 35 Floor Finishing Guide
- ☐ 36 "Fire Protective System"
- ☐ 37 Books
- ☐ 38 Books
- ☐ 39 Books

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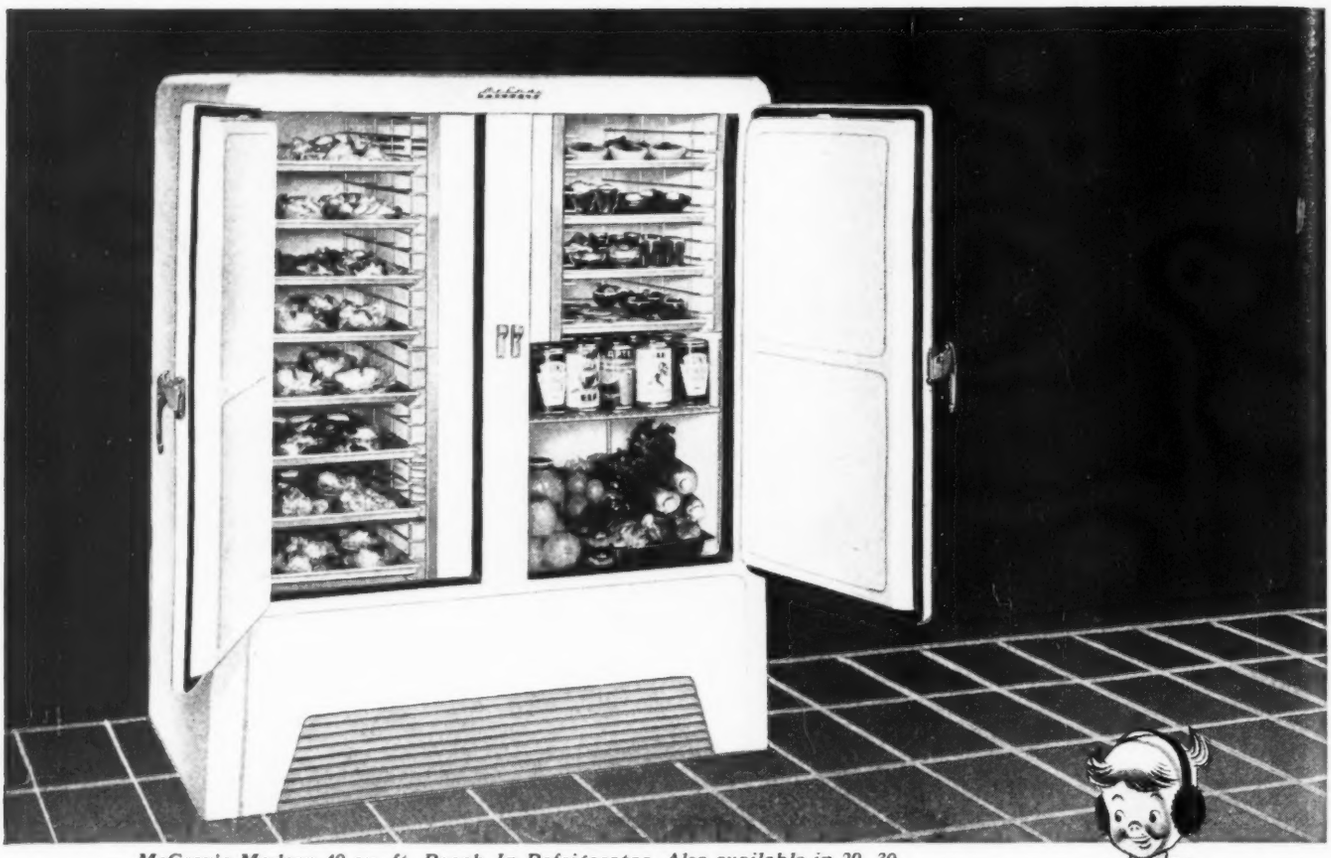
MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc 919 N. Michigan Ave., Chicago 11, Ill.



McCray's Modern 40 cu. ft. Reach-In Refrigerator. Also available in 20, 30 and 60 cu. ft. sizes . . . for better, easier kitchen organization.

Another McCray KOLDFLO . . . with genuine "Up-From-Under" refrigeration

Only McCray makes the genuine KOLDFLO "up-from-under" system of refrigeration—controlled circulation of cold air that rises up from the bottom without blasting the surfaces of perishables. It's one of the many quality features of McCray's streamlined 40 cu. ft. Reach-In for hospital, diet kitchen and institution use.

Picture this McCray Reach-In in your kitchen . . . giving more than ample storage space for perishables . . . keeping them at the peak of freshness . . . providing so many features that make for fast clean-ups and greater sanitation. It's the top choice of people who strive for the utmost efficiency in kitchen management. Distributors in all principal cities. Check your telephone directory . . . or write directly to the McCray Refrigerator Company, 866 McCray Court, Kendallville, Indiana.

Go Modern with . . . McCray KOLDFLO

FEATURES

BUILT FOR SERVICE! All-steel, welded shell . . . sturdy, reinforced, heavily insulated doors . . . heavy-duty, satin finish chrome hardware.

BUILT FOR CONVENIENCE! Spacious, one-piece, seamless porcelain interior with rounded corners . . . full-length service doors . . . adjustable, removable metal shelves . . . special racks to hold 36 trays. Self-contained condensing unit, semi-hermetically sealed.

BUILT FOR PROTECTION! Instant temperature control . . . maintains proper degree of humidity . . . balanced circulation with famous McCray KOLDFLO Refrigeration.